IMPLEMENTATION MANUAL

REDUCING TRAUMA AMONG PSYCHIATRIC WORKERS

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

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ABOUT THIS MANUAL

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

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Funding Statement

This manual was created as part of the project, *Violence prevention and trauma reduction in psychiatric healthcare workplaces: Leveraging facilitators and overcoming barriers to implementing evidence-based practices*. The project team includes researchers from the Waypoint Centre for Mental Health Care and The Royal, and was funded through WorkSafeBC's 2024 Innovation: Proof and Prototyping grant.

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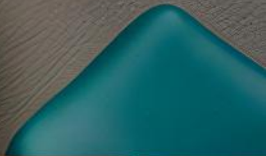
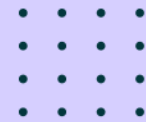
INTRODUCTION



This section includes:

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

INTRODUCTION



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Manual Overview

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

Building on the 12 recommendations for psychiatric hospitals detailed by Hilton et al. (2020a), this manual is an accumulation of literature reviews, multi-site surveys, healthcare worker interviews, focus groups, and interest-holder planning.

This manual includes two key components:

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

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

PROJECT BACKGROUND

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The Problem

Healthcare providers are at heightened risk for PTSD and other mental health problems due to workplace violence exposure and other potentially traumatic events (Carleton et al., 2019; Stelnicki et al., 2020). In addition, healthcare workers face the extraordinary stresses related to COVID-19 and the ongoing post-pandemic healthcare workforce challenges (Galanis et al., 2021; Morgantini et al., 2020). Slightly over half of healthcare workers (62%) report experiencing workplace violence (Liu et al., 2019), including 16% of psychiatric hospital workers experiencing post-traumatic stress disorder (PTSD; Seto et al. 2020). Evidence-based recommendations exist for preventing psychological injuries among healthcare workers (Hilton et al., 2020). The current critical situation in healthcare makes it imperative to implement these recommendations yet all the more challenging for organizations to adopt new research and translate it into policies and programs.

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

A previous WorkSafeBC-funded project found that one in six people working in psychiatric hospitals in Ontario met the screening cut-off for probable post-traumatic stress disorder (PTSD; Seto et al., 2020). PTSD was uniquely related to exposure to workplace violence, which was directly experienced by two-thirds of staff (Hilton et al., 2020). Furthermore, both critical incidents of violence and chronic workplace stressors increased the risk of PTSD (Hilton et al., 2020). While individual burnout plays a mediating role in PTSD, chronic stress related to healthcare working conditions increase both burnout and PTSD (Ham et al., 2022). Organizational and managerial support are key components of workplace psychological injury prevention (Rodrigues et al., 2020, 2021).

PROJECT BACKGROUND

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

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

There are few evidence-based interventions to prevent or reduce PTSD in healthcare settings. A scoping review of workplace interventions for hospital nurses found only six eligible studies, which focused on individual level, educational and therapeutic interventions (Liyanage et al., 2021). A broader scoping review of existing strategies to support the psychological health and safety of criminal justice and forensic healthcare workers found that most strategies again focused largely on training to reduce stigma, encourage help-seeking, and increase resilience (Canning et al., 2024), despite limited evidence of long-term effectiveness (Anderson et al., 2020; Vanhove et al., 2016). In contrast, a systematic review identified violence prevention and mental health care for healthcare workers exposed to violence as the most promising targets for PTSD prevention (Hilton et al., 2022). Further, there is limited attention to vulnerable populations such as women (Canning et al., 2024), despite the preponderance of women among healthcare workers and potential gender differences in workplace exposures, stressors, and PTSD risk and recovery (Hilton et al., 2022).

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Recommendations for Reducing Trauma Among Psychiatric Workers

Twelve evidence-based recommendations for hospitals to undertake were initially developed, based on research (surveys, focus groups, interviews, literature reviews) and interest-holder consultations (with employers, employee associations, government ministries and public service agencies). The recommendations (found **here**) were posted on a public website in early 2020. In 2024, we began translating the recommendations into guidelines and steps to support implementation. We aimed to build a manual that considers post-pandemic demands on healthcare systems as well as an understanding of the extent to which hospitals have used the recommendations, any successful policies and programs to reduce workplace violence and related trauma among workers, and current needs.

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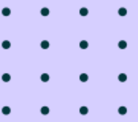
Engage in primary prevention to reduce staff exposure to critical events

Objectives include:

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

PRIORITY 1



Engage in primary prevention to reduce staff exposure to critical events

Since the pandemic, individuals admitted to mental health care settings have presented with higher clinical acuity, increasing the risk of critical events and related harm to healthcare staff (Ham et al., 2023). Direct exposure to critical events, such as assaults and threats, are key risk factors for Post-Traumatic Stress Disorder (PTSD) symptoms in staff working in healthcare settings (Hilton et al., 2021). This finding was also reflected in the survey and focus groups conducted by our team at Waypoint Centre for Mental Health Care and The Royal, where workplace violence was identified as contributing to increased PTSD risk among forensic inpatient unit staff. This evidence highlighted the need to prioritize primary prevention efforts to reduce critical events.

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Action: Strengthen safety by standardizing risk management processes and optimizing physical environments to reduce risk.

Priority 1 focuses on prevention strategies that reduce staff exposure to critical events. Through our focus group sessions, we have identified five objectives involving multiple layers of action across patients, staff, physical environments, policies and procedures, and organizations. Patient-level actions include individual risk assessment and engagement with patients and families in violence prevention. Staff-level actions include risk assessment and risk management. Environmental actions include creating safer physical spaces and strengthening security design. Policy and procedure actions include identifying gaps in existing policies and developing standardized prevention practices. Organizational actions include building a stronger infrastructure for violence prevention through organizational survey and data-driven trends. These actions can be supported by baseline assessment, ongoing monitoring, and outcome evaluation to promote long-term sustainability.

OBJECTIVE 1

Standardize individual-level risk management

Worked Example

This objective focuses on supporting organizations to select, implement, and consistently use violence risk assessment tools.

This may include identifying validated tools through literature searches, establishing timepoints for when risk assessment should occur, and defining clear processes for communicating and reporting risk information. Standardizing these processes can help ensure that patient risk information is identified and communicated within the organization.

Individual-level risk management and violence risk assessment was identified as a key theme in our focus groups, and is an evidence-based practice that can help reduce workplace violence exposure.

Violence risk assessment plays an important role in preventing violence against staff as the first step for safety planning from the time a patient is admitted to care. According to our survey, the consistency of risk assessment tool use varied across organizations. Some organizations did not use violence screening tools at all, while others used them only for certain patients or in selected care plans.

Focus group participants mentioned that risk assessment tools need to be mandatory during patient admission and the alerts need to be embedded into the Electronic Medical Record (EMR) system. The EMR system should include psychological safety alerts that identify the list of factors and recommendations to reduce staff's exposure to violence. Within EMR systems, safety alerts need to be upfront and clearly identifiable.

Many organizations are already using EMR systems to support violence risk assessment and communication. For example, the Centre for Addiction and Mental Health has implemented a risk flagging system within its electronic health record system to help identify and communicate potential safety risks (Paterson et al., 2019). The risk flag is upfront when a healthcare professional opens the EMR system and the alert will pop up to communicate the nature of the risk (Paterson et al., 2019). Risk flags include aggression, sexual aggression, weapons, arson, letter of trespass, and unauthorized leave of absence (Paterson et al., 2019). Implementation of the updated EMR system was found to decrease the total number of incidents and the average incidents per patient with a risk flag (Paterson et al., 2019).

Another key point is the timing of assessment, as participants highlighted the importance of secondary reassessment of patient violence after initial patient screening. Screening tools like Dynamic Appraisal of Situation Aggression (DASA) and Brøset Violence Checklist (BVC) are intended for imminent violence prevention, often within 24 hours after assessment (Dickens et al., 2020). According to the Public Services Health and Safety Association (2017), violence risk assessment for mental health and addiction needs to happen at the first point of contact with a healthcare worker and needs to be repeated in each shift. However, the timing may vary depending on the type of violence screening tool used and the organization's specific processes. Therefore, organizations should consult internal stakeholders and the original tool guidance before proceeding.

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Objective 1: Standardize individual-level risk management

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

Step 1: Assess and Identify Gaps

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

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

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SMART goal example - *Complete validated tool(s) for assessing individuals' risk of violence in the healthcare setting at specified timepoints (e.g., intake, monthly, annually).*		
0	1	2
No gaps; goal achieved	Minor gaps: in progress but review or more work needed	Major gaps: goal not in sight
Notes: Examples - Individual-level risk assessment is present in our unit, but it has not been updated for a long time and it is not a mandatory part of admission. Literature search and staff survey is needed to update and embed it into our system.		

Objective 1: Standardize individual-level risk management

SMART Goal Fillable Worksheet

Create SMART statements based on your organizations's goals. Use the tables below to rate the difference between the SMART goal and the existing state at your organization, and add any notes on gaps.

SMART Goal:		
0	*1*	*2*
No gaps *Goal achieved*	**Minor gaps** *In progress but review or more work needed*	**Major gaps** *Goal not in sight*
Notes:		

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SMART Goal:		
0	*1*	*2*
No gaps *Goal achieved*	**Minor gaps** *In progress but review or more work needed*	**Major gaps** *Goal not in sight*
Notes:		

Step 2: Plan and Improve

Now that you have assessed your SMART goals, review the gaps you have identified. If you have identified a mix of major and minor gaps, you may consider whether any goals with gaps require prioritization due to time-sensitive factors, such as temporary availability of funding or other resources, a critical event review, or an inquest. You may also consider whether addressing a minor gap would make a meaningful difference and help move the objective closer to having no gaps.

If you have no major gaps, review the objectives with minor gaps and proceed to work through the planning and improvement steps with these objectives. This will occur more often as you work your way through the manual with your first objectives and return to the assessment step to identify your next objectives, as you continue your efforts to prevent violence and reduce workplace-related trauma.

This section will guide you through the tasks needed to create and implement your plans for violence prevention and trauma reduction. As you work through the gaps related to your objectives, re-assess the objectives in Step 1, then return here to plan and implement your next changes.

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Task: Create an operational plan for each objective that you are working on by completing the table provided. These activities are based on data gathered from our focus groups, knowledge exchange events, and other interest-holder consultations. You may choose to use additional or alternative evidence-based activities you may find.

Objective 1: Standardize individual-level risk management

Operational Plan Worked Example

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

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

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Objective 1: Standardize individual-level risk management

Operational Plan Template

Use this template to develop an operational plan for your organization's goals.

Activity	**Definition**	**Actor** Who will do this? (i.e., team or position of person responsible)	**Action** What will they do?	**Dose** How much? (i.e., Number of staff reached, number of sessions)	**Frequency** How often? (i.e., once a month, once a year)	**Expected outcome (metrics)** What do you hope to achieve?	**Resources needed**	**Timeline** Start - Finish
Sub-goal:								

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Step 3: Implement

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

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

Objective 1: Standardize individual-level risk management

Implementation Plan Worked Example

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

Implementation goal What are our goals	**Strategies** How to achieve these goals	**Person(s) responsible**	**Unit or service area + target groups**	**Supports needed**	**Anticipated adaptive challenges**	**Timeline** Start - Finish	**How will we know if we are making progress?** What data will be used?
Installation							
Pilot evidence-based violence risk assessment tools in one or two units	Identify staff groups and units that need to be informed. Provide drop-in sessions and provide presentations on the updated violence risk assessment tools.	Unit managers Risk management team Practice lead	Start with one unit (i.e., med surg, inpatient, outpatient) Target all staff providing violence screening	Time and support to attend the sessions	Staff may have limited availability Staff may have negative perspectives on the updated assessment tools	April 2027 - June 2027	Feedback from staff
Gather feedback from staff who used the updated violence screening tool	Conduct staff focus groups. Engage staff in risk management team	Data evaluation team Research team	Staff on the unit that had the pilot	Time needed to distribute and complete the focus groups	Staff have limited availability/ interest for focus group session	June 2027 - August 2027	Number of focus groups completed/number of staff engaged

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Objective 1: Standardize individual-level risk management

Implementation Plan Worked Example

Implementation goal What are our goals	**Strategies** How to achieve these goals	**Person(s) responsible**	**Unit or service area + target groups**	**Supports needed**	**Anticipated adaptive challenges**	**Timeline** Start - Finish	**How will we know if we are making progress?** What data will be used?
Initial Implementation							
Deliver staff training on screening, documenting, and incident reporting**	Assess the current training on violence screening, look back on staff survey, update training based on the pilot and staff survey	Frontline staff representatives Training department Learning and Development Occupational health department	Across the hospital to frontline staff	Resources needed to update the training Time needed for staff to complete the training	Limited time availability from staff	November 2027 - March 2028	Number of staff trained Number of new lessons and modules
Full Implementation							
Embed validated violence prevention screening tool	Work with IT team to embed the updated violence prevention tool into documentation, care planning, incident reporting, orientation, and Electronic Medical Record	IT Team EMR team Data analytics Clinical managers	Across the organization All staff that conduct violence screening	Time, resources, and funding needed from the IT team	Capacity of the EMR system	Oct 2027 - March 2028	Violence screening tool embedded in the workflow

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Objective 1: Standardize individual-level risk management

Implementation Plan Template

Use the blank table on below to develop an implementation plan for your organization's goals.

Implementation goal What are our goals	**Strategies** How to achieve these goals	**Person(s) responsible**	**Unit or service area + target groups**	**Supports needed**	**Anticipated adaptive challenges**	**Timeline** Start - Finish	**How will we know if we are making progress?** What data will be used?
Installation							
Initial Implementation							
Full Implementation							

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Step 4: Monitor and Evaluate

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

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Task: Identify the measures, indicators, and data sources you will use to monitor implementation, assess progress, and evaluate whether planned strategies were delivered as intended. Use the space provided to document how implementation quality, uptake, and outcomes will be reviewed over time, and how findings will be used to refine and sustain the work.

Types of Measures

The Donabedian Framework was used to identify measures of implementation quality.

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

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

Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

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

Operational definition	Data collection method/ data source	Who is responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Outcome Measures: Main outcomes to improve						
Number of workplace violence incidents reported by hospital workers within a 12 month period (Health Quality Ontario, 2019)	The number of reported workplace violence incidents is available via your organization's internal reporting mechanisms.	Data analytics team	120 incidents reported in the 12 months before implementation	10% reduction within 12 months, from 120 to 108 or fewer incidents	Quarterly, with annual review	102 incidents reported in the 12 months after implementation, representing a 15% reduction
Process Measure: The activities you are doing to achieve your desired outcomes						
Number of completed violence risk screening tools	Number of EMR record with completed violence screening tool	Implementation team EMR team Data analytics team	355 completed screenings in the 12 months before implementation	20% increase within 12 months	Monthly for the first 6 months, then quarterly	500 completed screenings

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Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

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

Operational definition	Data collection method/ data source	Who is responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Structural Measures: Organization foundations that support practice						
Percentage of staff aware of changes that have taken place (Lyver et al., 2024)	Post-implementation staff survey	Data analytics team Unit Leads	Not applicable	80% of staff aware of the change	Days after each change implementation	78% of staff aware of the change
Balancing Measures: These are to assess for unintended consequences elsewhere in the system						
Staff time required to complete screening or documentation	Conduct time audits or ask staff to record estimated completion time during a trial period.	Clinical managers Quality improvement team Data analytics team		Maintain screening at 15 minutes or less per patient	Monthly for first 3 months, then quarterly	14 minutes per patient

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

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Objective 1: Standardize individual-level risk management

Measurement Plan Template

Use this template to develop a measurement plan for your organization's goals.

Operational definition	Data collection method/ data source	Who is responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Outcome Measures: Main outcomes to improve						
Process Measure: The activities you are doing to achieve your desired outcomes						
Structural Measures: Organization foundations that support practice						
Balancing Measures: These are to assess for unintended consequences elsewhere in the system						

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