NSW GOVERNMENT | Health Mid North Coast Local Health District

Document ID: **MNC-PRO-0011-22**

Title: Code Black Safety Huddle Procedure

Site where document is utilised: MNC

Description: To ensure that all Code Black participants are able to participate in a safety huddle prior to proceeding with a request to restrain a patient.

Keywords: Duress, Response, Safety, Huddle, Restraint, HSA, Health, Security, Assistant, Code, Black

Directorate: Nursing Midwifery & Workforce

National Standard: [NS2]

Replaces Existing Guideline: **false**

Related Legislation, NSW Health Policy or Circular, or other MNCLHD Documents:

Protecting People and Property NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies

PD2020_004 Seclusion and Restraint in NSW Health Settings

PD2015_001 Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach

MNC-PRO-0103-17 Security Arrangements for Patients in Custody

GL2015_007 Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments

GL2012_005 Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People

PD2017_043 Violence Prevention and Management Framework for NSW Health Organisations

PD2020_047 Incident Management

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Executive Director/Director Nursing Midwifery & Workforce

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MNCLHD Procedure

Document Registration Number:

MNC-PRO-0011-22

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Mid North Coast
Local Health District

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Executive Director/Director: Simon Joice

Consultation: MNCLHD wide.

Authority:

MNCLHD Health Safety & Wellbeing Committee

Management Authority:

MNCLHD Senior Executive Team Meeting

Title

Code Black Safety Huddle Procedure

Related Policy

IB2013_024 Protecting People and Property NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies

PD2020_004 Seclusion and Restraint in NSW Health Settings

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Purpose

To ensure a Safety Huddle occurs before every proposed physical restraint of a patient. The safety huddle is to ensure code black response participants are able to discuss all safety aspects and decide on the safest planned response to the proposal to restrain the patient.

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Risk Management

All staff, visitors and patients who access Mid North Coast Local Health District (MNCLHD)facilities are entitled to work or receive care in a safe environment.

Failure to properly discuss and plan each individual restraint occurrence increases the risk of injury to staff and patients.

Wherever possible a Safety Huddle involving all members of a Code Black response should occur at the Code Black muster point to discuss staff safety, share pertinent information and, if decision is to proceed with restraint, assign roles to team members and *plan the activity* prior to attempting to restrain an ill or disturbed patient.

The Safety Huddle will allow all stakeholders to discuss whether a proposed restraint activity can be safely undertaken, taking into account the available resources of the local Code Black team.

In some instances the local Code Black Response team may be overmatched by the person/ situation and to restrain the patient safely may not be possible. In these cases Police assistance should be sought and the team must concentrate on making the environment as safe as possible for others while waiting for their arrival.

Restraint activities pose a significant risk to staff and patients 2016-sn-003.pdf (nsw.gov.au) and all avenues short of restraint should be considered and enough time allowed for their application, prior to any restraint activity.

NSW Health staff must only use seclusion and restraint:

- where there is a legal basis to do so
- as a last resort to prevent serious harm, usually associated with ASBD
- to allow administration of lawful medical treatment
- after less restrictive alternatives, including prevention strategies, have been trialled or considered, where safe to do so
- proportionate to the risk of harm
- for the minimum time necessary

The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support, if this is necessary, provided by security staff at the direction of clinical staff.

Any incidents relating to this procedure are to be reported in the incident management system (IMS+). Any failure or gap in the Code Black Safety Huddle Procedure should be reported to the management authority listed on the document. If a significant risk is perceived or identified with the implementation of the actions specified in this document, a risk assessment form as per Risk Management-Enterprise Wide Policy and Framework should be undertaken and escalated to Clinical Operations and Clinical Governance with mitigating strategies identified. The risk can be reported to

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the District Manager Health Safety and Wellbeing and to the appropriate governance committee for more information and follow up.

Generic information on Risk Management for use in documents can be accessed at: http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015_043

Procedure

CONSIDERATION OF WHETHER THE RESTRAINT CAN BE SAFELY UNDERTAKEN WITH THE STAFF/ RESOURCES AVAILABLE IS THE PRIMARY CONCERN OF THE SAFETY HUDDLE.

IF IN DOUBT POLICE SHOULD BE CALLED**.**

Background

Failure to properly discuss and plan each individual restraint occurrence has been demonstrated to increase the risk of injury to staff and patients.

Once staff have attended the **Code Black muster point** a safety huddle should occur to discuss and plan the safest response.

Where an aggressive or potentially aggressive incident occurs the appropriate initial response by staff is to implement aggression minimisation strategies such as verbal de-escalation. The use of physical restraint is only to be used when all other strategies to de-escalate the situation have been assessed, implemented or have failed to contain the matter e.g. offering negotiation, mediation and counselling.

It is preferable to 'wait out' a crisis if possible.

Unnecessary or over vigorous restraint can have a lasting traumatic effect on the patient, this may then adversely affect patient behaviour during future presentations at the Hospital.

Minimising the incidence/ restrictive force of restraint is likely to assist a patient's wellbeing while in our care and may positively impact their behaviour in any future presentations.

Restraint: is the interference with, or restriction of, an individual's freedom of movement. For the purposes of this procedure restraint is to be taken to mean physical or medication restraint by staff.

Team Restraint: Is a situation in which a person's behaviour poses a high enough risk of injury or distress that a coordinated approach of a team of people (minimum x 5) is required to restrain that person so that medical care can be administered.

Responsibilities:

During the safety huddle code black participants must ensure that a dynamic risk assessment of the environment is completed prior to the restraint and the following information is identified:

Weapons. All possible weapons are removed from the area if possible. This includes medical equipment/ furniture and any items worn by duress response team members that could be used as weapons including lanyards, name badges, pens, scissors, earings etc.

Other people. All other people (including family members) must be asked to leave the area unless documented clinical reasons preclude this action.

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Exits: All team members must orientate themselves so as to ensure that the exit/s are readily accessible by all team members during the restraint activity. All obstacles that may impede staff being able to rapidly exit from the area should be removed where possible prior to attempting to restrain the patient.

All participating HSA's will report to the muster station where duress has been activated and will be met by the clinical team leader.

Multidisciplinary Team Risk Assessment

- An immediate Dynamic Risk Assessment will be undertaken during the *pre-restraint Code Black safety huddle* with input from all members of the multidisciplinary team prior to beginning any proposed restraint activity.
- Any plan of action to proceed with restraint, or not, will be decided only with agreement of all duress response participants during pre-restraint safety huddle.
- Each proposed restraint must be planned prior to the commencement of the activity. Relevant roles are discussed and assigned to relative staff members during this discussion.
- Safety of the staff and patient is a priority. If the perceived risk of physical harm to staff or other persons escalates rapidly, staff may be required to close any door as necessary to contain the risk and protect other people. (Seclusion is preferable to aggressive physical interaction).
- A decision to not restrain due to safety concerns must be documented and the reasons recorded.

Risk Management

No staff member is to place themselves, or be directed by others to place themselves, at unnecessary risk in carrying out their duties. (Work Health and Safety Act 2011 No 10 Part 5 Division 6 Section 84)
Where there are concerns about public safety the police should be called.

General Principles

- Team restraint is only to be used when all other strategies and techniques to de-escalate a situation have been attempted. Sufficient time must be allowed for these strategies to work before proceeding to a restraint. The safety and dignity of the staff and patient are to be maintained as much as possible.
- Restraint should be used for the minimum time necessary or as reasonably practicable
- *Where practicable standing restraint (as per VPM techniques) should be attempted in preference to a floor restraint*
- *Where practicable sitting restraint (as per VPM techniques) should be attempted in preference to a floor restraint*
- Use of restraint must consider the principles of care in the least restrictive manner, while providing safety for all, *National Safety and Quality Health Service Standards 3.9., Safety and Quality Health Standards>Comprehensive Care Standard>Minimising Patient Harm>Action 5.34 States Safely manage aggression, and minimise harm to patients, carers, families and the workforce*
- Least restrictive care for the patient must not to be achieved at the expense of staff safety.
- Restraint must be proportional to the acts of the patient, any action out of proportion to the danger they are placing themselves or others in, may be considered assault;
- All members of the Code Black team must have completed the mandated Seclusion and Restraint Violence Prevention and Management training.

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Patient Care Handover
A meaningful handover of the key security issues relating to that patient must be received by the HSA team leader and relayed to other HSAs responsible for providing care to that patient/staff.

The following matrix provides a quick reference that reflects what **IS** and what **IS NOT** within the scope/role of NSW Health Security Staff as per NSW Health Protecting People and Property manual.

Please refer to INFORMATION SHEET 1 – Role of security staff working in NSW Health

Activity	IN scope	OUT of scope
It IS the role of NSW Health security staff to:	✓	
Restrain physically (that is, holding the person temporarily), using a reasonable amount of force, if decided by participants at pre-restraint safety huddle	✓	
A patient or visitor who has assaulted the security staff, other staff, another patient or another visitor and who is (in the reasonable opinion of the security staff in attendance) likely to continue to assault and where the security staff believe the restraint is necessary to defend themselves or another, and report to police as appropriate	✓	
A patient or visitor who (in the reasonable opinion of the security staff in attendance) is threatening to imminently assault the security staff, other staff, another patient or a visitor, and where the security staff believe the restraint is necessary to defend themselves or another, and report to police as appropriate	✓	
A patient or visitor who has destroyed or damaged significant property of the NSW Health Agency and who is (in the reasonable opinion of the security staff in attendance) likely to continue to destroy or damage the property, and where the security staff believe the restraint is necessary, and report to police as appropriate	✓	
A patient or visitor who is (in the reasonable opinion of the security staff in attendance) threatening to imminently destroy or damage significant property of the NSW Health Agency, and where the security staff believe the restraint is necessary, and report to police as appropriate.	✓	
A patient after a medical practitioner has informed the security staff in attendance that the patient is incapable (either temporarily or permanently) of giving consent and the Medical Officer requests that the patient be restrained for the purposes of the Medical Officer carrying out urgent and necessary medical treatment to save the life of the patient or to prevent serious damage to the patient (referred to in this document as a non capacity patient).	✓	
It is NOT the role of NSW Health security staff to:		
Detain people suspected of engaging in criminal activity, or at the direction of another person		✓

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Activity	IN scope	OUT of scope
Detain (ie stop from leaving) or forcibly retrieve individuals except in circumstances involving an involuntary mental health patient (refer to clause 4) or a non-capacity patient (refer to clause 2.2.5).		✓
Restrain a patient so as to assist in the provision of medical treatment, except in circumstances involving an involuntary mental health patient (refer to clause 4) or a non-capacity patient (refer to clause 2.2.5).		✓
Detain (ie stop from leaving) a child who is the subject of an Assumption of Care Order, where the parents or carer attempt to remove that child.		✓
Search individuals without their consent except in circumstances relating to involuntary mental health patients (refer to clause 4)		✓
Forcibly remove individuals from NSW Health premises (the circumstances where security staff can be involved in escorting people from NSW Health premises are set out in Chapter 14 (Role of Security Staff) Protecting People and Property		✓
Manage high risk incidents such as those involving prohibited weapons or hostage situations.		✓

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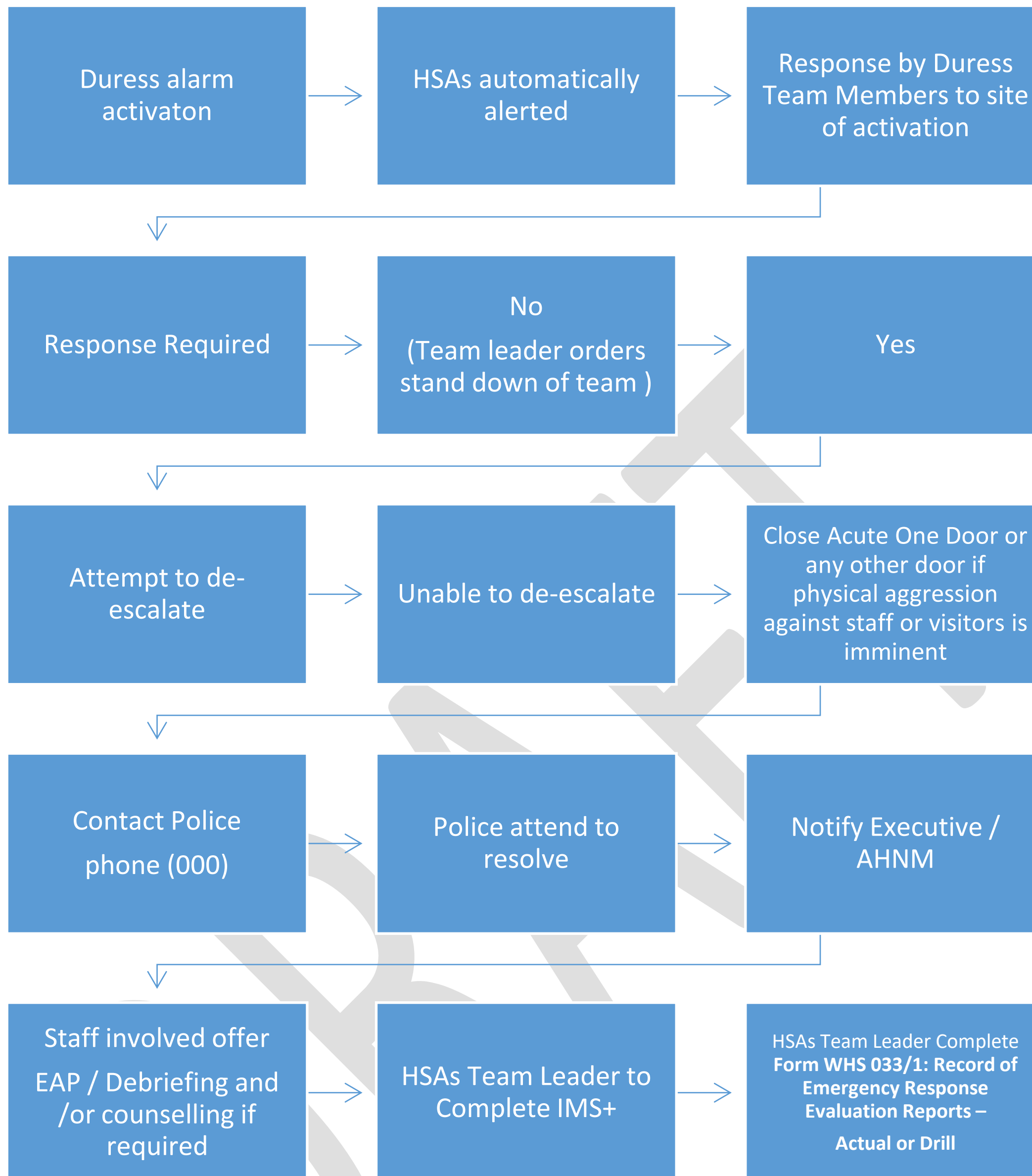
DURESS RESPONSE FLOWCHART



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HANDOVER FOR HEALTH SECURITY ASSISTANTS MUST INCLUDE:

I – Introduction

Self, immediate care team, environment, and patient

Patient name (preferred) and age (legal implications)

S – Situation

Legal status / current physical location of person /primary risk/reason for HSA presence

B – Background

Current diagnosis

Current behavior– recognized triggers and de-escalating strategies

History of violence/aggression and possible weapons (concealed)

A – Assessment

Risk level (low / medium / high) and category:

- Aggression
- Vulnerability
- Deliberate Self Harm
- Absconding
- Sexual safety
- Suicidality

R – Recommendations

Current interventions

Planned movement (transfer to ward / radiology) or care interventions

Visitor access

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CONTROLLED ENVIRONMENT (ie at admission / change of shift / location)			
	Objectives	**HSA to HSA**	**Nurse to HSA**
Introduction	• Introduce yourself, your role • Identify immediate care team - team leader, Nurse & Doctor in charge of patient • Ensure familiarity with clinical environment • Ensure all staff providing care have a duress alarm that has been tested at shift commencement and familiar with its activation	• Hi I'm Patricia, I've been providing inpatient special for Matt this morning. • The nurse responsible for Matts care is Mary and he's admitted under Dr. Jones. Sarah is team leader.	• Hi Bill, I'm Mary, the nurse looking after Matt.
Situation	• State the immediate clinical situation • State particular issues or concerns • Identify risks • Current physical location of person / primary risk/reason for HSA presence	• Matt has been admitted under the mental health act • He was brought in by 3 police officers in handcuffs after threats of self-harm. • Police advised that Matt had been aggressive with them	• I noticed you've received handover from Patricia already – is there any additional information you need?
Background	• Current diagnosis • Current behavior– recognized triggers and de-escalating strategies • History of violence/aggression and possible weapons (concealed)	• Matt has a history of frequent presentations with paranoia, schizophrenia and previous incarceration • His identified triggers are being called 'mate', police presence, and he doesn't like needles. • Identified management strategies have included talking about fishing	• Matt's last admission was prolonged with wound complications and I understand from his Mum that they're worried his length of stay might be extended again for some reason.

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		and cars. He is a keen supporter of Collingwood. • During previous admissions the immediate presence of his mother has sometimes become a factor that has escalated his behavior.	
Assessment	Identify assessed Risk level (low / medium / high) and category: • Aggression • Vulnerability • Deliberate Self Harm • Absconding • Sexual safety • Suicidality	• Matts aggression risk is high • His current mood is quiet and he's been sleeping intermittently • Sedation was administered early and we expect it to last another hour • He's currently at a low risk of self-harm but a high risk of absconding • He has made some sexually inappropriate comments to nursing staff	• Matt has been compliant with us but we've been supporting his mood with regular medications. • He's made some sexually inappropriate comments to me already and I'm feeling really uncomfortable.
Recommendation	• Identify the current plan/recommendations • Identify any planned patient movement and expected delays • Identify further actions or assessments are required • Identify observations / assessments needed	• Matt has stated that he will not be staying overnight and team restraint would be required if he attempts to abscond • I strongly recommend you hit the duress at the first sign of aggression. • I recommend that we make no attempt to stop him if he attempts to leave without a restraint team • **Do you need any other information?** • Introduce Matt and family / carer to Bill (oncoming HSA). Explain that Bill will now be looking after him and encourage Matt to let Bill know if he needs anything.	• Patricia has reinforced that I should not hesitate to activate my duress at the first sign of aggression and that we will need a restraint team if he attempts to abscond. • I will follow your lead if any situation escalates Matt's behavior and he becomes aggressive or tries to leave. • There are no planned interventions other than regular medications and no expected movement of Matt this shift. • Let me know what you need.

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CODE BLACK – PERSONAL THREAT			
	Objective	**HSA to Nurse**	**Nurse to HSA**
Introduction	• Introduce yourself, your role, location • Identify Patient	• Hi I'm Bill, the HSA team leader	• Hi Bill I'm Sarah, the nurse looking after Matt
Situation	• State the immediate clinical situation • If urgent say so	• What do you need?	• Matt's behavior has been escalating. He's just thrown a chair at his nurse and is demanding to leave. We need to give him sedation.
Background	• Provide relevant clinical history and background	• Has he been searched for weapons? • Has this happened before and if so, how did it go? • Is there any possibility that I can talk him down?	• He has been searched on admission and we did not find any weapons. • Last admission he had to be restrained multiple times for sedation and he's been really inconsistent in his response to a show of numbers either backing down when you guys arrived or escalating
Assessment	• Identify clinical observations or behaviors of concern • Outline your observations of the problems / issues	• Who is the clinical lead if we need to do a restraint? • Have we exhausted all de-escalation processes?	• The clinical lead will be RN Jones if we need a controlled restraint. • Do you think we have the right VPM trained team if we need a controlled restraint?
Recommendation	• State what assistance is required • Be clear about what you are requesting and the timeframe	• We will try to deescalate before restraint • Steve and I will take upper limbs, Jo and Bob will take lower limbs (this is not rigid, participants may end up having to restrain a different limb	• I'll be here as the runner while RN Jones takes the **clinical lead**.

		depending on events) • We will try standing restraint first • We may attempt seated restraint if possible • I'll give the tap when we're ready to enter	

TEAM PHYSICAL RESTRAINT - ROLES & RESPONSIBILITIES

The duress team comprises a clinician, team leader and team members who are trained in aggression minimisation and management techniques. The team shall provide a supportive role for managers where Manager and/or staff determine;

- Assistance is required with an aggressive or potentially aggressive situation
- Assistance is required to provide legal restraint for clinical purposes

Note: Under a Risk Assessment process where the team leader or 50% of the Duress Response Team agree the situation is beyond the capacity of the team, further external assistance shall be called e.g. Police. If any person declines to take part, the team leader shall ensure that the required numbers of staff are available to the team.

Team Leader

A person will be appointed as team leader. This will usually be a clinical person such as the Nurse Unit Manager, Nurse-In-Charge of shift or the primary nurse or Medical Officer. The final decision for a team physical restraint will be made by the whole multidisciplinary team. The Team Leader must conduct and document a debrief for all staff before being released to return to daily duties.

Note: In an emergency situation, staff in attendance may initiate physical restraint. At the first practicable opportunity the patient's' medical officer and nurse-in-charge of the unit at the time must be notified.

Minimum Requirements

The Team Leader minimum standards are;

- Completion of category 1,2 & 3 components of training outlined in PD 2017-043 Violence Prevention & Management Training Framework pertaining to their role
- Physically capable to perform the role
- Good negotiation skills - Good communication and team leadership skills
- Sound knowledge of the site and Department locations
- Good working knowledge of this procedure

The Team Leader will;

- Assess that the Duress Response Team members are wearing the minimum Personal Protective Equipment (PPE) e.g. Gloves and Eye Protection;
- Ensure that all Duress Response Team members (including self) have removed any personal items that could be damaged (glasses) or sharp implements on their person that could cause harm to self or others (pens, lanyards, name tags etc);
- Assess the degree of risk to the person and/or staff;

- Have a clear understanding on the reason for use of restraint;
- Assess the patient and any relevant history to assist in controlling the situation;
- Assess if in possession of weapons;
- Assess the environment;
- Use the least restrictive and safest option available;
- Ensure adequate personnel are available to safely implement the restraint;
- Plan the restraint process and clearly communicate intended plan to the duress team members;

All staff members must work to the following principles;

- The decision to proceed to a restraint activity *does not automatically mean* restraint on the floor or ground.
- Negotiating with the patient while restrained in a standing position is preferable to a floor restraint if possible.
- Negotiating with the patient while restrained in a sitting position is preferable to a floor restraint if possible.

Allocation of staff roles;

- Limbs and head protection (As per VPM training the team should be able to automatically take up positions or adapt as necessary as circumstances change)
- Opening/Closure of Doors
- Other persons – removal from area
- Medication (If required) – as determined by the appropriate clinician
- Explanation to team of process to be followed

A gesture (a nod or a tap on a leg between the leaders of the team is recommended as verbal cues can warn the patient in advance of the commencement of the restraint) is used by the team leader to communicate to all team members to initiate the physical restraint. When the gesture is given by the team leader the members of the team will simultaneously approach and restrain the person.

On entering the area where the person requiring restraint is located the team leader will;

- Position themselves where appropriate in front of other team members, at a safe distance from the person requiring restraint (in safety zone as per VPM training) with hands held at chest height palms outwards (showing that no weapons are held) and holding a non-threatening stance.
- All other staff should adopt a similar non-threatening stance.
- The lead person should avoid any sudden movements and speak in a calm manner taking care to avoid escalating the situation.
- Ensure they are the only person who communicates to the person throughout the procedure.
- Identify to the person who they are.
- Attempt to engage the person clearly and calmly by name and provide an explanation of why the team is here and what the team wants to happen. (recommend 'Steps for de-escalation') (TOP 5 strategies shared during the huddle can be useful at this point).
- Seek the person's co-operation by asking / encouraging the person to stop the aggressive behaviours or take oral medications.
- If appropriate, offering the person options in what happens going forward can assist them to retain a measure of self-agency in the process, and is preferable to giving direct instructions (telling them what to do).
- Reassure the person that they are safe.

- Acknowledge the persons responses and feelings through using reflective listening techniques and by validating verbal responses where possible as per 'Steps for de-escalation'.
- Observe the person for any signs of activity or body language which may indicate the fight/flight response or sudden physical escalation.

Following the incident complete necessary documentation Duress Response Report (Appendix 1) and coordinate a debrief if required.

- Will ensure that the next of kin (if consented by the patient) are notified as soon as possible after the incident and this is documented in the patient health care record. Any disagreement should be noted and the reason recorded.
- Will ensure appropriate monitoring of the patient occurs post the team restraint.

Duress Response Team

The duress response team comprises primarily of a clinician and Health & Security Assistants, however trained nursing staff are also expected to participate where required.

The clinician is responsible for safeguarding the person (watching for signs of positional asphyxia etc) during the restraint and for supporting the person's head.

Minimum Requirements

Duress Response Team minimum standards;

- Completion of all necessary components of training outlined in PD 2012-008 Violence Prevention & Management Training Framework pertaining to their role
- Physically capable to perform the role
- Good communication skills - Sound knowledge of the facility Department locations
- Good working knowledge of this procedure

The Duress Response Team members will perform the following in sequential order;

- Arrive at the scene of the incident as soon as possible
- Obtain a synopsis of the incident from the most senior available staff member / team leader.
- *Discuss range of response options, taking into account the composition of duress team and size and aggression level of patient/ visitor.*
- *Reach consensus decision by all members of response team on whether restraint can be safely undertaken with available resources.*
- Indicate whether further assistance is to be called, e.g. psychiatric registrar, police etc;
- Indicate their intention to manage the situation, or support those already at the scene;
- Where appropriate, team members will place themselves in a position where they can be seen by the aggressive patient;
- Position themselves in pairs in a V shape to either side of and a little behind the team leader prior to approaching if the area is small, such as a patient room.
- If there is sufficient space, the team may fan out around the person and approach simultaneously from the sides as per VPM techniques once the signal is given.
- Team members are not to talk to the person. The Team Leader is the only one to talk to the person;
- Team members are to remain silent and alert during the procedure;
- While monitoring the situation and prior to a restraint beginning, team members are to avoid using their phones or putting their hands in their pockets (to decrease possibility of patients becoming suspicious of innocent activities)
- Do not get involved in any way with what the person is saying, avoid personalising the things that may be said to you;

- Look for signs the person may be about to escalate to physical aggression;
- Watch closely for the signal and respond quickly to the direction / instruction of the Team Leader;
- If the person makes physical contact in an aggressive manner with any team member or any other person, then the team members must respond immediately
- Adopt a comfortable, non-threatening demeanour during approach;
- Respond promptly to the direction / instruction of the Team Leader;
- Utilise least restrictive care while ensuring safety for all;

Work Location Staff

Staff who work in the location of the duress incident are to;

- Work under the instruction of the Duress Response Team Leader;
- Ensure the safety of self and others in the work area;
- Comply with local procedures where established.
- Ensure that onlookers (including other staff) do not gather in exits or obstruct paths of retreat.

Post Incident Management

After an aggressive incident has been resolved the 'in charge' person in the Unit / Department shall implement the following action;

Ensure all documentation is completed within the health care record and must include the following;

- Date and time of incident;
- Description of events leading to the incident;
- Alternatives considered;
- Method used to restrain patient;
- Patient's response;
- Other treatments used;
- Any injuries sustained by staff or others;
- Frequency of review by staff
- Incident entered into IIMS

A debrief is to be held for all staff involved at the completion of the incident and the Duress Response Report completed, along with the security register which must be signed by all Health & Security Assistants involved and forwarded to the Manager Patient Support Services for review.

- Debriefing is recommended following all aggressive incidents and is mandatory following severe incidents, incidents where physical injury occurs, and incidents where physically coercive actions have been implemented and must include all staff involved
- Ensure any alarms that have been activated are re-set at the Security Control Panel.
- Notify the relevant Executive.
- Where a need is identified, relevant Executive shall authorize additional follow-up action within 24-72 hours of incident occurring e.g. Organisation Debrief, Critical Incident Stress Debriefing, Employee Assistance Program

Monitoring, Evaluation and Review

The Mid North Coast Local Health District is committed to regular monitoring, review and evaluation of its procedures and guidelines. The necessary steps to ensure this

happens will be initiated through IMS+ and will occur in collaboration with staff members and educators

Key words: Duress, Response, Safety, Huddle, Restraint, HSA, Health, Security, Assistant, Code, Black

References

PD 2015_043 NSW Health Risk Management - Enterprise-Wide Risk Management Policy and Framework available at:
http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015_043

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Further Code Black Resources available at Ministry of Health: Code Black Arrangements

Appendices

APPENDIX 1: WHS 033/01 DURESS RESPONSE REPORT

Record of Emergency Response Evaluation Reports –

Actual or Drill

LOCATION:

DATE OF INCIDENT/DRILL:

TIME OF INCIDENT/DRILL:

TYPE OF INCIDENT/DRILL:

FIRE & EVACUATION ☐
CHEMICAL SPILL ☐
BOMB THREAT ☐
MEDICAL EMERGENCY ☐
/CARDIAC ARREST
DURESS ALARM ☐
OTHER: ☐

INCIDENT/DRILL WAS:

SCHEDULED ☐
UNSCHEDULED ☐

1. What went right and what went wrong in responding to the incident/drill?: (refer to 'tip' included in this procedure)

2. How could the management of the incident/drill have been improved?:

3. Recommendations to Executive Management?:

4. Changes in Policy and/or procedure required?:

5. Review Team (Name/Designation):		
6. Team Facilitator (Name/Sign/Date):		

Note: Forward original to Facility Health and Safety Committee and retain copy for your records

Reference: Work Health and Safety Procedures Manual MNC_WHS-003-17 page 222