### Duress Response - Code Black Policy

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<th>TRIM Document No</th>
<th>SD16/6790</th>
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<tr>
<td>Policy Reference</td>
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**Related MOH Policy**

- Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- NSW Health, Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance approach (PD2015_001)
- NSW Health, Violence Prevention & Management Training Framework for the NSW Public Health System (PD2012_008)

**Keywords**

- Code; black; duress; emergency; response; personal; threat; 222; aggression; attack; debrief; hot; cold

**Applies to**

- All Staff

**Clinical Stream(s)**

- All Clinical Streams

**Tier 2 Sign-off**

- Katherine Moore, Director Clinical Governance & Risk

**Date approved by SLHD Policy Committee**

- 14th July 2016

**Author**

- SLHD WHS Coordinator/ CEWD Workforce Development Consultant (WHS)

**Status**

- Active

**Review Date**

- 14 July 2020

**Risk Rating** *(at publication)*

- L (Medium)

**Replaces**

- N/A

**Version History**

<table>
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<tr>
<th>Date</th>
<th>V.2 – Published 7 July 2017</th>
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<tr>
<td></td>
<td>• Clarification of the role of medical officers in 9.2</td>
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<td>• Clarification regarding debriefing at Section 9.3 and 9.4</td>
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<tr>
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<td>• Addition of new ED training to appendix 1</td>
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<td>• Addition of Appendix 6, 7, and 8 and explanatory text</td>
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Section 9.4 related to cold debriefs
V.1 – Published 11 August 2016
SLHD Duress Response - Code Black Policy

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SLHD Duress Response - Code Black Policy

1. Introduction

To ensure a consistent approach to the management of potential or actual aggressive incidents Sydney Local Health District (SLHD) has developed a framework for duress response (including ‘personal threat – code black’ response).

An act of aggression can be verbal or physical with potential to cause physical or emotional harm to a person or damage to property.

This framework will assist SLHD facilities/services to ensure that they are meeting the minimum requirements for the personal threat – code black team response and management.

This Policy is in line with SLHD’s Strategic Goals:

- For our patients to be treated with dignity, compassion and respect
- For our staff to work in safe, respectful, healthy and productive workplaces

This Policy describes the requirements of SLHD in accordance with:

- AS 4083-2010 Planning for emergencies – Health care facilities
- AS 3745-2010 Planning for emergencies in facilities

2. The Aims / Expected Outcome of this Policy/Procedure/Guideline

This policy aims to provide strategic guidance to facilities in the management and governance of duress response / personal threat - code black incidents and teams.

It will ensure a consistent approach to personal threat - code black team response and management.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 11 - Patient aggression.

Appropriate management of aggression requires timely and coordinated intervention by trained staff (including clinical and non-clinical) to reduce the impact of harm to patients, staff members and others.

4. Policy Statement

This policy provides for strategic governance of Duress response/Personal Threat - Code Black incidents and teams in SLHD. Facilities and services will have their own contextualised procedure/response plan for specific management of Duress and Personal Threat - Code Black incidents.

SLHD will ensure that:

- appropriate arrangements for providing a timely and effective response to duress situations (including response to duress alarms and code black incidents) are developed, implemented and regularly tested, in consultation with staff and other duty holders, and safety and security experts
- Staff members and others who may be required to respond to a duress alarm are appropriately trained to undertake that role, in line with the requirements set out in NSW Health Policy, Violence Prevention and Management Training Framework (PD2012_008).
5. **Scope**
This Policy applies to all SLHD staff at all SLHD services and facilities

6. **Resources**

**Identification of Code Black Team Members**
Where a Code Black team response is in place the Code Black team members must be identified and trained. All team members must be physically able to participate in a restraint and complete the Category 1, 2 and 3 of the Violence Prevention Management (VPM) training (see Appendix 1 Categories of Staff and Training Requirements).

Consideration must be given to identifying Code Black team members so that all shifts are appropriately resourced.

A list of identified Code Black team members should be sent to the Centre for Education and Workforce Development so that they can be flagged in the Learning Management System (LMS) as Category 3 staff. CEWD must also be contacted where new Code Black team members are identified or if flagging needs to be removed.

New members of a Code Black team must complete the Category 3 VPM training before participating in a Code Black response.

7. **Implementation**
A Duress response process must be in place in each facility/service to:

- Summon as a priority sufficient numbers of skilled personnel to a developing incident or an incident in progress in order to prevent or minimise injury or other harm, contain the incident until external assistance arrives or resolve the incident; and

- Demonstrate support for staff, patients and others in threatening or violent situations.

The exact nature of the duress response will vary from facility to facility depending on the nature of the incident, the type of the facility or unit within the facility, availability of staff to respond, and access to external services such as police or private security firms. However a duress response must be available to each shift and be planned and prompt.

The term **Code Black** is used in a duress response when a person is facing a personal threat or physical attack.

Scenarios where a duress response may be required can fall into one of two categories - clinical or corporate incidents. These incidents are defined in the NSW Health Security Manual Protecting People and Property as follows:

**A ‘clinical incident’** is where the safety of a staff member, patient or others is threatened by the behaviour of a patient. These types of incidents would largely involve a clinical response, with assistance provided by security personnel or police where necessary.

The aim is to get sufficient numbers of skilled personnel to the patient as soon as possible in order to maximise the chances of a good outcome by de-escalating the event, protecting the safety of the patient and others, treating any underlying medical cause, and facilitating an appropriate patient management plan to mitigate future events.

**A ‘corporate incident’** is where the safety of a staff member, patients or others is threatened by the behaviour of an individual or a group of persons who are not patients, or where there are other threats such as robbery. These types of incidents largely involve a security or police response, rather than a response by clinical staff.
The required reporting and recording of the incident must occur as soon as possible after the event utilising the local processes e.g. IIMS. Where the incident involved a patient, information should be communicated to the medical officer (MO) in charge of the patient’s care, if the MO was not present during the incident.

The following are examples of when a Code Black response may be required:

- Any incident with a weapon
- Any situation where verbal or physical aggression escalates beyond what the person in the situation can control
- A verbally aggressive incident which has the potential to escalate

**District Responsibilities**

- Provision and evaluation of VPM training to all identified Code Black team members
- Review of local Code Black incident data at the SLHD District Security Meeting.
- Review of SLHD Duress Response - Code Black policy

**Facility and Service Responsibilities**

- Development and review of local Duress Response / Personal Threat - Code Black procedures with sign off from facility executive. These should include shift and geographical coverage (where relevant), roles and responsibilities
- Identification of appropriate Code Black team members and release of these staff members to attend VPM training: personal safety and evasive techniques (1 day) and team restraint (3 days). The code black team where possible should be multidisciplinary and include nursing, security, medical staff and others where indicated.
- Scheduling and review of regular duress response / Code Black drills and desktop awareness exercises
- Ensuring that hot debriefs are conducted immediately post incident
- Ensuring that cold debriefs are conducted post incident when indicated (e.g. incident did not go to plan, concerns are raised, staff/patient was injured etc)
- Undertaking investigation of duress response / Code Black incidents as required and implementing any necessary changes
- Completion of monthly Duress Response / Code Black reports to be reviewed locally and sent to the SLHD District Security Meeting (see Personal Threat – Code Black Facility/Service reporting template – Appendix 2)

**Note:**

- For high risk areas such as Mental Health and Emergency Departments (ED) there may be a local duress response that will be escalated to the facility for an additional security response.
- For work areas such as standalone community health centres there will be a duress response team that can assist with de-escalation but where escalation of the response is required the Police will be called on 0-000.
- Where working in isolation (e.g. standalone unit not on a facility/community centre site or in a clients home) staff will escalate to Police immediately on 000 as required.

8. **Key Performance Indicators and Service Measures**

- 100% of facilities and services have an endorsed local Personal Threat - Code Black procedure
- Debriefs and investigations are conducted post incident
- 100% of identified staff have attended VPM training

Regular documented drills and desktop awareness exercises are conducted
9. Procedures

The code black response is set out below and summarised in Appendix 3 Duress Response - Code Black Flow Chart.

Further requirements for aggression management and responding to violence are set out in NSW Health policy Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance approach (PD2015_001) and NSW Health Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies.

9.1 Initiate a duress response – personal threat / code black

Role of Staff

A Code Black duress response should be initiated by any member of staff requiring back-up support, in situations where they are concerned for their own safety and/or the safety of others due to threatening, abusive or assaultive behaviour.

No staff member is to put themselves at personal risk at any time. In response to any personal threat, staff will immediately take reasonable action to protect themselves and others.

If possible, staff should warn and seek assistance from other staff members. This can be done by initiating a duress response by alerting staff in the immediate area and summoning assistance by:

- Using a fixed or mobile duress alarm and/or
- Dialling the emergency phone number (222 in hospital facilities, 0-000 (internal) or 000 (external) in the community)
- If on external hospital grounds staff should access the closest help point, internal phone or call the hospital switchboard directly using a mobile phone

A staff member initiating a code black response through switchboard (222) must (if possible and safe to do so) inform the switchboard operator of:

- Their name and title
- Location of the incident
- Nature of the incident (e.g. Code Black – assault, Code Black - weapon)
- This will initiate a ‘personal threat - Code Black’ team response
- Whether the Police are required immediately (in this case he staff member will be connected directly to the Police by switchboard staff). A Code Black will also be initiated.
- Safest entry point for responding personnel and nominate a control point.

Once the duress call is made:

- Where possible, staff should nominate a designated officer to assist with coordinating the arrival and entry of the Code Black Team or Police to the incident.
- N.B. Staff can notify the NSW Police at any time on “0-000” (i.e. dialling 0 for an outside line). This should be done, if required, in addition to initiating the local response procedures.

See Appendix 4 for emergency flip chart procedures (personal threat - Code Black)

Role of Switchboard

Prioritise answering ALL 222 calls

- Operator should answer 222 calls by saying “Please state the nature of the emergency”.
- Page all members of the Code Black Team on receiving a personal threat - Code Black call
• Contact the police when requested to do so

NOTE: If the staff member calling is unable to provide details in regards to the incident and the event note as much information as possible and initiate the Code Black response immediately as the caller may be in immediate personal danger.

• Include ‘Police called’ on the Code Black group page of any Police response requests made.
• Page Code Black Team “Stand down” as soon as possible when informed by Team Leader, Security or area of initiation

9.2 Duress response – personal threat / Code Black

Role of Code Black Team

• Respond to ‘Personal Threat - Code Black’ duress events
• A Code Black team leader (nominated by the team) will coordinate the team’s activity and allocate specific roles as and where required
• Assess the situation in collaboration with local senior staff present (e.g. NUM/department manager)
• Take charge of the Code Black incident (where appropriate)
• Lead de-escalation and restraint process (if required) in collaboration with local staff
• Determine if police need to be called (if not already done)
• Participate in the restraint process as required (physical restraint should only be considered as a last resort) see also the Ministry of Health Information Sheet 1 – Role of Security Staff
• In response to a patient incident sedation should only be considered if the other forms of critical incident management have been unsuccessful (i.e. de-escalation/distraction and warning, physical restraint).
• Assist with and participate in hot and cold debrief process
• Ensure that the staff initiating the Code Black or manager of the area enter an IIMS
• Complete the Code Black Evaluation Form (Appendix 5)

The role of Medical Officers in a Code Black Response

Medical Officers (MO) are considered to be non-restraint members of the Code Black Team (except in some high risk areas in Mental Health where they have been trained in team restraint so they may participate in restraint if necessary). There is a requirement for MOs to attend Code Black Responses, with responsibilities outlined below.

The MO is responsible for the following:

• Assembling at the main or designated entry of the location for situation briefing
• Following the instructions of the Code Black Team Leader during the Code Black Response.
• Assessing any medical condition that has contributed to the behavioural disturbance and instituting appropriate management.
• Liaising with the Code Black Team Leader to discuss proposed management strategies, which may include consideration of chemical or physical restraint in situations where less restrictive measures have been unsuccessful. Any application of physical restraint is directed by the Code Black Team Leader.
• Ensuring the physical welfare and safety of the patient/person should restraint be required.
• Medical management during and immediately following the restraint process.
• Liaising with the patient’s treating team for ongoing management where applicable
• Documentation of clinical information and medical assessment related to the Code Black Response. In the case of a patient, this documentation would occur in the patient’s medical record.
Participate in both hot and cold de-brief processes following a Code Black Response

**Code Black Involving Weapons:** Members of the Code Black Team answering an alert that involves a weapon (e.g. knife or gun) are not to place themselves in danger. Their role is limited to securing the area and preventing people from entering. Situations involving a weapon are to be managed by the police.

**Code Black Involving Visitors or Staff:** In the event of an aggressive incident involving a visitor to the hospital or a member of staff an initial Duress call should be made to security / the switchboard on 222 or via a fixed or portable duress alarm, where these are not available this can be made directly to Police (0-000 (internal) or 000 (external). Where appropriate a code black team response may also be initiated if required.

When needed, the police may also be requested to attend by security or the senior staff member in the work area. Upon the arrival of the police the Code Black Team Leader and/or Security staff member are to hand over to the Police and provide a briefing of the situation.

### 9.3 Post event management

- Check that the area is safe
- Provide any first aid
- Notify staff in the area and contact switch to stand down the code black response
- Code black team leader or senior staff member conducts a Hot Debrief (see below)
- A cold debrief should be scheduled if indicated

### 9.4 Debriefing

A debrief is required following all Code Black incidents.

- **Hot Debrief** – to be conducted immediately after an incident and is facilitated by the team leader. The following should be included;
  - Discussion about what went well and what didn’t
  - Offering of EAP or other relevant services to those involved
  - An opportunity for all involved to make comments
  - Completion of appendix 5 – code black evaluation form or equivalent documentation (questions on the form can be used as a basis for discussion)
  - Decision on whether a cold debrief is required e.g. incident did not go to plan, concerns are raised by staff, staff/patient was injured, see also list below.

- **Cold Debrief** – if indicated is to be conducted within 1-2 weeks post incident. Department Managers, N/MUMs are responsible for managing the cold debrief process, providing feedback to staff involved in incidents and ensuring the documentation relating to each cold debrief is completed.

A cold debrief is required when identified in the hot debrief as described above or if any of the following occurred:

- Person/s physically assaulted
- Damage to property
- Any external agency involvement e.g. Police, SafeWork NSW
- Any situation involving a weapon or object used to threaten another person
- if directed by the facility/service executive

The cold debrief should be controlled and look at issues without the emotion that immediately follows an incident. This can be facilitated by someone who was not involved in the incident and will form part of the incident investigation. The following should be included:

- Time, date and location of the incident
- Type of incident - abuse, threat, assault
- Who was abused/threatened or assaulted, and their role/s
- Client/person who committed the act and relevant details
- How the incident arose and progressed - what worked and what didn't work
- Activity underway at the time, including detailed description of any high-risk activities
- Nature of injuries/damage sustained
- Contributing causes
- Potential or actual costs
- Corrective action taken
- Follow-up recommendations
- A reminder that EAP and other support is available if the staff feel it is necessary.

The completed Appendix 5 Code Black Evaluation Form or equivalent documentation can be used as a basis for the cold debrief discussion.

The following documentation is provided to assist managers conducting and recording the cold debrief.

- Cold Debrief - Post Incident Assessment (Appendix 6): this form is for the manager of the cold debrief to guide them in their investigation of the incident to ensure that all pertinent information is collected/reviewed
- Cold Debrief - Staff feedback (Appendix 7): this form is to be provided to staff involved in the incident prior to the cold debrief to enable them to provide information that they feel should be discussed.
- Cold Debrief – Summary (Appendix 8): this form is to be completed post the cold debrief to allow feedback to be provided both to staff involved in the incident and to the executive/committee to allow reporting to the district.

On completion of the above debriefs and incident review the department manager/person in charge should ensure that lessons learnt and opportunities for improvement are shared with other staff who may be impacted by them. This can be in a staff meeting or by other means e.g. email.

Any related IIMS reports should be reviewed and updated with relevant information including implementation of corrective actions and follow up recommendations.

9.5 Reporting

All Code Black incidents must be recorded in the incident reporting system (IIMS – injury and incident management system). Ward/department staff involved in the incident will complete the IIMS.

The Code Black Team leader will coordinate the completion of Code Black Evaluation Form (Appendix 5 or approved equivalent documentation) and submit it to the local facility/service quality manager.

Where a patient is involved a ‘Clinical’ IIMS should be completed, in this instance the Code Black Team Leader (in addition to the above) must also:
- Record the incident details in the patient’s clinical record
- Post an alert in CERNER if appropriate
- Ensure a Behavioural Management Plan has been completed
- Ensure the next of kin (NOK) has been informed

If the incident involves an injury to a staff member, visitor or contractor or they are the aggressor then a ‘Staff Visitor Contractor’ (SVC) IIMS should be completed.

A ‘Property Security Hazard’ (PSH) IIMS should be completed for property damage.
9.6 Data Monitoring

Data monitoring will include (but not be limited to) the following:

Facilities and Services will complete the ‘Personal Threat – Code Black Facility/Service reporting template’ (Appendix 2). This information will be used by facilities/services to monitor their Code Black procedures for effectiveness and make changes where required. This template will also be sent to the SLHD District Security Meeting for review.

This includes:

- Record of Code Black incidents – number of incidents
- Record of hot debrief completion and referral of the incident to cold debrief
- Summary of lessons learnt or issues with potential LHD wide impact
- VPM training attendance
- Completion of drills and desktop exercises

There is also a SLHD Quarterly Report on Emergency Management that includes the number of Code Black and other emergency incidents.

9.7 Drills and Desktop Awareness Exercises

All staff (particularly Code Black team members) must participate in regular training drills and/or desktop exercises to ensure that they are able to carry out the duress process including the code black alert and that Code Black team members’ skills and knowledge remain current.

- Duress/Code Black drills must be carried out at least annually in high risk aggression areas (e.g. ED, mental health, high risk aged care wards). These drills must include the Code Black team. Facilities/services must conduct a risk assessment to determine the location and frequency of their code black training drills.
- Code Black awareness training desktop exercises should be carried out at least once a year in all wards/departments and outpatient clinics not completing a drill.
- Participation in training drills and desktop exercises should be recorded and maintained by the facility/service and sent to CEWD for entry in the learning management system (LMS).

10. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Aggressive Behaviour</td>
<td>Aggressive behaviour is behaviour that causes, or threatens to cause, physical or emotional harm to others. It can include verbal abuse, physical abuse or assault and the destruction of property.</td>
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<tr>
<td>Code Black</td>
<td>The term Code Black is used in a duress response to identify when a person is facing a personal threat or physical attack.</td>
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<tr>
<td>Duress response</td>
<td>A process to:</td>
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<td>• Summon as a priority sufficient numbers of skilled personnel to a developing incident or an incident in progress in order to prevent or minimise injury or other harm, contain the incident until external assistance arrives or resolve the incident; and</td>
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<td>• Demonstrate support for staff, patients and others in threatening or violent situations.</td>
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11. **Consultation**
Katherine Moore Director, CG&R
General Managers and Service Directors
SLHD Security Coordination Committee
Security Managers
Facility/Service WHS Managers, and via them Health and Safety Representatives
SLHD Joint Consultative Committee

12. **Links and tools**
- NSW Health Information Sheet 1 – Role of Security Staff
- NSW Health Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies

13. **References**
- NSW Health Information Sheet 1 – Role of Security Staff
- NSW Health Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
- NSW Health Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance approach (PD2015_001)
- NSW Health Violence Prevention & Management Training Framework for the NSW Public Health System (PD2012_008)
- AS 4083-2010 Planning for emergencies – Health care facilities
- AS 3745-2010 Planning for emergencies in facilities
### Appendix 1 - Categories of Staff and Training Requirements

<table>
<thead>
<tr>
<th>Category of Staff</th>
<th>Description</th>
<th>SLHD Targeted Areas</th>
<th>Training Requirement</th>
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| 1                 | Staff identified as being at risk of workplace violence | ALL STAFF | Online  
1. VPM – Promoting acceptable behaviour in the workplace  
2. VPM - Awareness |
| 2                 | Staff identified as working in high risk areas | NSW Mandatory Training Matrix  
- Emergency Department (RNs)  
- Critical Care (RNs)  
- Child and Family (RNs)  
- Mental Health (Nursing, Allied Health & Medical, other staff with direct patient contact)  
- Security  
SLHD Locally Targeted  
- Community (Clinical)  
- Aged Care (Clinical)  
- Drug Health Services (Clinical) | TARGETED STAFF (except ED)  
Online  
Category 1 +  
VPM – An Introduction to legal + ethical issues (online - prerequisite for the face to face training)  
Face to Face (1 day)  
VPM Personal Safety + Evasive Techniques  
ED STAFF  
Online  
Category 1 +  
1. VPM – An Introduction to legal + ethical issues  
2. Introduction to aggressive behaviours  
3. De-escalate aggressive behaviours  
4. Manage aggressive behaviours  
Face to Face (1 day)  
1. Physical skills training (1 day) |
| 3                 | Staff identified as potentially involved with the physical restraint of other individuals | NSW Mandatory Training Matrix  
- Mental Health (Inpatient Nursing & Allied Health)  
- Security  
SLHD Locally Targeted  
- Code Black Teams (restraint participants)  
- Emergency Departments  
- Psychogeriatric Units | TARGETED STAFF (except ED)  
Category 1 + Category 2 +  
Face to Face (3 day)  
VPM – Team Restraint Training  
ED staff complete the program outlined in above in Category 2 training. |
| 4                 | Those who supervise Category 1, 2 and 3 staff | Managers | Online  
Category 1, 2, or 3 (as targeted) + VPM for Managers |

Note: A list of identified Code Black team members should be sent to the Centre for Education and Workforce Development so that they can be flagged in the LMS as Category 3 staff.
Appendix 2 - Personal Threat – Code Black Facility/Service Reporting Template

**Personal Threat – Code Black Facility/Service reporting template**

<table>
<thead>
<tr>
<th>Total number of code black incidents for reporting period</th>
<th>Percent of ‘hot’ code black debriefs completed</th>
<th>Percent of incidents referred for ‘cold’ code black debriefs</th>
<th>Percent of Code Black Evaluation Forms completed</th>
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**Summarise any lessons learned or issues with potential LHD wide impact:**

<table>
<thead>
<tr>
<th>VPM training</th>
<th>Category 1 (ALL Staff)</th>
<th>Category 2 (Personal safety)</th>
<th>Category 3 (Team restraint)</th>
<th>Category 4 (Managers)</th>
</tr>
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<tbody>
<tr>
<td>Number completed (total)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number targeted</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>% completed</td>
<td></td>
<td></td>
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**Drills and desktop exercises**

<table>
<thead>
<tr>
<th>Number of code black drills completed / reporting period</th>
<th>Number of code black exercises completed / reporting period</th>
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**Facility Contact:**

Once completed please send to: SLHD Security Committee for review via your local Director, Corporate Services or nominated person

Compliance with this Policy is Mandatory
Appendix 3 - Duress Response - Code Black Flow Chart

Duress Alarm Activation → Local response

- Code black via staff member to switch (222)
- Code black via staff member to switch (222)

Code black response activation by switchboard

Contact code black team → Contact code black team, call Police 000, 0-000 (if requested)

- Code Black Team proceeds immediately to location and reports to Code Black Team Leader
- Code Black Team Leader briefed about situation by Ward NUM / Nurse in Charge / Senior Staff Member
- Code Black Team Leader to assess situation (can be upgraded to Code Black with Police if required).

For Patient, Visitor or Staff Instigator
- Situation de-escalated, no further assistance required

For Patient, Visitor or Staff Instigator
- Weapon involved or situation too dangerous for Code Black Team to manage, confirm/call Police to attend. Code Black Team Leader / Security to meet and brief Police on arrival

Without putting self at risk, Code Black Team to remove any other people present and secure area, whilst awaiting Police

Police manage incident

- Person / Patient managed by Police processes
- Patient managed – admit, transfer to other ward or hospital, treatment reviewed
- Patient managed, remains on the ward, treatment reviewed

Code Black Team Stand Down Post Incident Management
- Team Leader to ensure IIMS reports and Code Black Evaluation Form are completed

Note: For high risk areas such as Mental Health and ED there may be a local duress response that will be escalated to the facility for an additional security response.

For work areas such as standalone community health centres there will be a duress response team that can assist with de-escalation but where escalation of the response is required the Police will be called on 0-000.

Where working in isolation (e.g. standalone unit or in a clients home - not on a facility or community centre site) staff will escalate to Police immediately on 000 as required.

If on external hospital grounds staff should access the closest help point, internal phone or call the hospital switchboard directly with a mobile phone.
IN THE EVENT OF A PERSONAL THREAT – (armed or unarmed persons threatening injury to others or themselves)

1. Take immediate action to protect yourself or threatened patient/person.
2. If not directly involved, leave the area and raise the alarm
3. Warn or seek assistance from other staff members. Trigger duress alarms where available

Retreat if safe – Dial (222 in facilities or 000 / 0-000 in community) and state:

- What the emergency is
- Where the emergency is
- If you are evacuating the area
- Your name

4. If you cannot retreat:
- Obey the offenders instructions
- Do only what you are told

5. When the danger has passed - Dial (222 in facilities or 0-000 in community) to report the incident

6. Record your observations quickly
   (i.e. description of offender, weapon, speech, mannerisms, tattoos, vehicle description, direction of travel etc.)
   - Preserve the scene of the crime
   - Co-operate with security and wait for the Police

PERSONAL THREAT

<table>
<thead>
<tr>
<th>R</th>
<th>Remain Calm</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Retreat – if safe to do so</td>
</tr>
<tr>
<td>R</td>
<td>Raise the Alarm</td>
</tr>
<tr>
<td>R</td>
<td>Record Details</td>
</tr>
</tbody>
</table>

CODE BLACK
## Appendix 5 - Code Black Evaluation Form

Affix patient label or if not a patient include details of aggressor here (if available)

<table>
<thead>
<tr>
<th>Name (last, first)</th>
<th>MRN (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>M.O.</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

**Location:**<br>**Date:**<br>**Time:**

**Team members in attendance:**

<table>
<thead>
<tr>
<th>Team Position</th>
<th>Name</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did sufficient members arrive for the incident to be managed safely YES NO (circle)
If no, who else should have been in attendance?

---

**Incident type:** (circle one)

<table>
<thead>
<tr>
<th>Patient procedure (E.g. resistive to routine medications)</th>
<th>Verbal Aggression by patient</th>
<th>Physical Aggression by patient to persons</th>
<th>Physical aggression to objects / environment by patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weapon involved or situation level resulting in Police Assist call</td>
<td>Verbal Aggression by other person</td>
<td>Physical Aggression by other person to staff / patients / visitors</td>
<td>Physical aggression to objects / environment by other persons</td>
</tr>
</tbody>
</table>

**Response**

<table>
<thead>
<tr>
<th>Time team paged</th>
<th>Time full team arrival at location</th>
<th>Time team stood down</th>
<th>Team responded in timely manner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes / No (circle)</td>
</tr>
</tbody>
</table>

**Situation Management**

<table>
<thead>
<tr>
<th>De-escalation</th>
<th>Physical Restraint</th>
<th>Chemical Restraint (Sedation)</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td></td>
</tr>
</tbody>
</table>

**Incident Summary**

---

Compliance with this Policy is Mandatory
### Outcomes

<table>
<thead>
<tr>
<th>Hot Debrief conducted: Yes / No (circle)</th>
<th>Cold Debrief required Yes / No (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, Date Arranged: / /

<table>
<thead>
<tr>
<th>Patient Injury during restraint</th>
<th>Response Team Injury during restraint</th>
<th>Staff injury</th>
<th>Visitor Injury</th>
<th>Property damage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Transfer</th>
<th>Local ongoing management plan</th>
<th>Additional Supervision recommendation</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td>Yes / No (circle)</td>
<td></td>
</tr>
</tbody>
</table>

### Reporting

- Clinical IIMS Number (where a patient is involved)
- Staff Visitor Contractor IIMS Number (where the staff / visitor / contractor are injured or are the aggressor)
- Property Security Hazard IIMS Number (for property damage)

### Team Leaders comments:

- Name: 
- Signature: 
- Date: / / 

### Facility/Service Quality Manager

- Name: 
- Date: 

RCA: Yes No (circle)

- Actions: 

### Facility/Service WHS Manager

- Name: 
- Date: 

Workers Compensation claim: Yes / No (circle)

- SafeWork NSW Notification: Yes / No (circle)

### Sign off by Facility/Service Quality Manager

- Signature: 
- Date: / / 

### Tabled at:

- Name: 
- Date: / / 

Compliance with this Policy is Mandatory
Appendix 6 - Cold Debrief - Post Incident Assessment

A cold debrief is required following a Duress/Code Black incident involving, but not limited to; injury to staff, external agency involvement, property damage, involvement of a weapon or if directed by the facility/service Executive.

The purpose of this form is to guide the facilitator of the cold debrief in the review of details surrounding the incident to enable them to provide feedback and recommendations.

The face to face cold debrief is to be conducted 1-2 weeks post incident with the minimum attendance of: 2 clinical staff present at the incident, a member of the response team and, if applicable, security representation.

Refer to the Code Black Evaluation Form (Appendix 5 or equivalent) and the IIMS form(s) for details recorded following the incident.

Ask staff who are unable to attend the cold debrief to complete Appendix 7 – Cold debrief staff feedback so their comments can be taken into account.

<table>
<thead>
<tr>
<th>Names and roles of employees attending debrief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Cold Debrief:</td>
</tr>
<tr>
<td>Location of Incident:</td>
</tr>
<tr>
<td>IIMS Number(s):</td>
</tr>
<tr>
<td>Who was involved in the incident?</td>
</tr>
<tr>
<td>Who was the person who committed the aggressive act? Provide relevant details.</td>
</tr>
<tr>
<td>How did the incident arise? Can you identify what the contributing causes may have been at the time?</td>
</tr>
<tr>
<td>What was the activity underway at the time? Provide a detailed description of any high risk activities.</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Were there any injuries/damage sustained? What was the nature of these?</td>
</tr>
<tr>
<td>How was the incident managed and by whom?</td>
</tr>
<tr>
<td>What was the planned response?</td>
</tr>
<tr>
<td>What actually occurred? (what worked/didn’t work)</td>
</tr>
<tr>
<td>What could have been done differently or better?</td>
</tr>
<tr>
<td>What corrective actions took place after the incident?</td>
</tr>
</tbody>
</table>

At the conclusion of the cold debrief use Appendix 8 - Cold Debrief Summary to create a report for your executive management team - including any further recommendations / actions to be taken.

IF STAFF FEEL THAT THEY MAY NEED SUPPORT OR ASSISTANCE PLEASE REFER THEM TO THE EMPLOYEE ASSISTANCE PROGRAM (EAP) SERVICE.
Appendix 7 - Cold Debrief Staff feedback (if unable to attend the debrief)

It is an expectation that a face to face cold debrief is conducted with the minimum attendance of: 2 clinical staff, a member of the response team, and if applicable, security representation, within 1-2 weeks of a Duress/Code Black incident occurring.

The purpose of this form is to enable staff involved in the incident to provide feedback and recommendations prior to the cold debrief if unable to attend.

**Case Study Summary:** Describe the incident that occurred.

How did the incident arise? Can you identify what the contributing causes may have been at the time?

How was it managed at the time?

What worked well?

What did not work so well?

What was your personal expectation to happen in this type of incident?

Any recommendations to improve the code black response:

IF YOU FEEL THAT YOU MAY NEED FURTHER SUPPORT OR ASSISTANCE PLEASE CONTACT THE EMPLOYEE ASSISTANCE PROGRAM (EAP) TO MAKE AN APPOINTMENT OR LET YOUR MANAGER KNOW.
Appendix 8 - Cold Debrief Summary

This form is to be provided following the completion of the Cold Debrief to staff and the Facility/Service Executive in relation to the key findings and recommendations related to the incident.

<table>
<thead>
<tr>
<th>Duress/Code Black Incident Summary:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident location</td>
<td>Incident Date/Time</td>
</tr>
<tr>
<td>IIMS No(s).</td>
<td>Cold Debrief Date</td>
</tr>
</tbody>
</table>

Brief description of the incident

<table>
<thead>
<tr>
<th>Key findings: what contributed to the event outcome both positively and negatively e.g. environment/communication/history</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recommendations/actions to be taken: (provide at least one for each level)</th>
<th>Who is responsible</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Organisational:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF YOU FEEL THAT YOU MAY NEED EXTRA ASSISTANCE PLEASE CONTACT THE EMPLOYEE ASSISTANCE PROGRAM (EAP) TO MAKE AN APPOINTMENT OR LET YOUR MANAGER KNOW.