CODE BLACK

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- This policy outlines the activation, response and management of a Code Black (personal threat) that may arise from a patient or individual confronting staff, patients and/or visitors in a violent or threatening manner
- Staff are required to:
  - Notice early signs of disturbed/aggressive behaviour
  - Contact Security to seek assistance at the first signs of aggression
  - Remove patients, staff and visitors from immediate danger and isolate the area
- Any member of staff can initiate a Code Black response:
  - Dial 2222 on an internal phone
  - Advise Switchboard operator of:
    - Your name and title
    - Code Black exact location
    - Patient or non-patient (if known)
    - Safest meeting point
  - Call 0-000 if police assistance is required e.g.: weapons, person armed, hostage taken
  - Complete Description of Offender Form as soon as practicable (Appendix 1)
- Team composition, roles, responsibilities (See Team Response Card (Appendix 6)
- Stand down when safe
- Incident Response report via Patient Flow Manager/AHNM
- Training available, depending on staff category

CHANGE SUMMARY

- Update from IIMS to ims+ throughout
- Link to NSW Health Protecting People and Property manual
- Addition: Appendix 7: SCHN Code Black SMIT and link
- Addition: Appendix 8: Graded Response Matrix (removed 1/12/22)
- 4/9/20: Minor review. Amended Appendix 7 (SMIT), QR code removed
- 16/10/20: Minor review. Amended Appendix 7 (SMIT), suggested changes from Policy Committee applied
- 1/12/22: Review.
    - Policy updated with a clearer definition to distinguish Code Black from managing challenging behavior through an updated purpose and scope.
    - Reference to Protecting People and Property Policy
    - Updated Response team composition reviewed and updated
    - Focus on when to call a Code Black and what occurs once activated - removal of information relating to prevention eg de-escalation techniques
    - Expanded instruction following patient/family/carer incidents eg documentation, informing the clinical team and reviewing the patient's care plan
    - Incidents to be recorded in ims+
    - Expanded information for staff Education and Training & inclusion of the Violence Prevention and Management Training Framework for NSW Health Organisations policy
    - Appendix 5: updated incident report template
    - Appendix 6: updated SMIT
    - Appendix 8: Graded Response Matrix removed - to be added to SCHN policy 'Graded Response for Safe and Respectful Behaviour' (in development). New Appendix 8: Code Black team allocation template

READ ACKNOWLEDGEMENT

- All staff should be made aware of this policy via their manager.
- All managers should read and acknowledge they understand the contents of this policy.

TABLE OF CONTENTS

Purpose and Scope

Code Black is defined as any incident where staff feel that there is a threat of physical harm or violence to themselves, other staff, patients and/or visitors. This can include assaults, verbal aggression threatening harm and physical violence, armed hold up and robbery.

Staff should activate a Code Black when a person is facing a personal threat or physical attack, which requires more than Security attendance. A Code Black is also a process to summon as a priority skilled personnel (clinical and non-clinical) 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 of physical harm or violence

Note: incidents involving weapons, an armed person or hostage situation is a matter for the police. The Code Black team is **not** expected to manage these incidents.

The purpose of this policy is to describe:

- Code Black risk identification and prevention
- Code Black activation process
- Roles and responsibilities of the response team
- Code Black stand down process
- Post incident management
- Review and governance of Code Black incidents
- Team response areas
- Legal context for management of violence
- Education/Training

This document is further supported by the Protecting People and Property Policy.

Glossary of Terms

ABBREVIATION	POSITION
AHNM	After Hours Nurse Manager
AMO	Admitting Medical Officer
CNC	Clinical Nurse Consultant
CPD	Clinical Program Director
CRMO	Chief Resident Medical Officer
DCO	Director Clinical Operations
DON	Director of Nursing
EAP	Employee Assistant Program
ED	Emergency Department
EDVPM	Emergency Department Violence Prevention & Management Program
eMR	Electrical Medical Records
ICU	Intensive Care Unit
ims+	Incident Information Management System
IRT	Incident Response Team
HIC	Hospital Incident Controller
HSFAC	Health Services Functional Area Coordinator
NM	Nurse Manager
NMPF	Nurse Manager Patient Flow
NUM	Nurse Unit Manager
RN	Registered Nurse
VPM	Violence Prevention Management

Risk Identification and Prevention

In order to prevent or minimise the need for a Code Black activation, each area should identify any risk of violence as part of regular safety huddles. The risk is to be assessed, managed and mitigated by the manager of the area or leader of the huddle. This includes identifying local resources that can assist in de-escalating the situation to prevent a Code Black activation e.g.: nursing, medical or allied health staff in the immediate vicinity or a neighbouring ward. Code Black situations are unique and require a specific response, dependant on the individual circumstances of the evolving situation.

As outlined in the Violence Prevention and Management Training Framework for NSW Health Organisations (PD201743), all staff are required to:

- Take notice of early signs of disturbed and/or aggressive behaviour and take any threats seriously
- Recognise, respond to and report incidents of aggressive, intimidating, threatening, disturbed or violent behaviour
- Seek assistance as early as possible, preferably before the situation escalates.
- Implement de-escalation techniques, including those outlined in the patient's behaviour management plan, if indicated. Consider contacting the admitting medical team to review the behaviour management plan, where the strategies implemented have not resulted in de-escalation.
- Remove patients, staff and visitors from immediate danger and isolate the area

People identified as high risk for disturbed and/or aggressive incidents are to have a documented behavioural management plan. This may include a written warning or conditional restricted access. The identified risks and management plan is to be discussed with the patient, parents and carers. The aim of these strategies is to reduce the risk of behaviour escalation and, where possible, reduce or eliminate the use of restraint.

For further information on de-escalation techniques, refer to

- Graded Response Matrix

Duress Alarms

High-risk areas of the hospital are fitted with 'duress alarms'. These can be activated to alert Security in situations of personal threat. The duress alarm may be used in the event Security is required for support. Where possible, following duress alarm activation, contact Security to provide further detail on #9845 2000 (CHW) or #9382 2847(SCH).

For incidents meeting Code Black criteria, call 2222.

Code Black Response Activation process

Code Black Activation

Code Black is an operational system for obtaining assistance when someone is presenting a threat to themselves, hospital staff, visitors or other patients.

Any member of staff can initiate a Code Black response.

To activate a Code Black:

- Dial 2222 on an internal phone
- Advise Switchboard operator of:
  - Your name and title
  - Code Black Exact Location
  - Patient or non-patient (if known)
  - Safest meeting point, as determined by the incident
- Call 0-000 if police assistance is required e.g.: weapons, person armed, hostage taken
- Complete Description of Offender Form as soon as practicable (Appendix 1)

Examples:

This is Jane Smith, Patient Flow Manager. Code Black, Sunny's Cafe

Unknown person. Enter from Main Entrance foyer, level 0.

This is Peter Jones, Hunter Baillie ward NUM. Code Black, Hunter Baillie ward,

Parent. Meet at Wade Ward (adjacent ward) entry.

The **Switch operator** is responsible for:

- Initiating the Code Black notification with details as supplied by the person activating the Code Black
- Ensuring a building name/ward unit and safety entry point (if given) is assigned to the Code Black notification to ensure prompt arrival of the Code Black response team to the safest entry point in the area

Team Composition, Roles & Responsibilities

The Code Black team consists of a multi-disciplinary team, working together to provide for the safe management of the incident.

All Code Black Response Team members must be clearly identified to the AHNM at the start of each shift (See Appendix 8) and must be VPM/EDVPM trained. For planned absences, a nominated, trained delegate is to be assigned and pager diverted for the duration of the absence.

If a Code Black has been activated, all members of the Code Black Response Team must respond immediately. The Code Black Response Team will oversee and coordinate the Code Black until the incident has been stood down.

Code Black Responder	Responsibilities
Hospital Incident Controller (HIC): **Nurse Manager Patient Flow** (or Delegate) (in hours) **After Hours Nurse Manager** (AHNM) (after hours)	• Assume incident control role as Code Black Response team leader • Escalate any further response that is required • Consider informing Campus or Precinct partners • Inform CPD/DCO/Executive on Call/HSFAC*, as relevant, of any issues or if further escalation or response is required e.g.: decision to lock down or evacuate (Code Orange) • Determine stand-down of the response • Inform Switchboard operator of Code Black stand down • Complete SCHN Incident Report Template – Appendix 5 • Identify person responsible for conducting incident review
NM /NUM /Team Leader/ Manager (for incident occurring in ward/unit/department)	• Patient and/or situation assessment, de-escalation if appropriate • Notification to medical team for attendance as a rapid response • Documentation of events in medical record • Complete ims+ notification • Advise parent or guardian of patient-related incident
Security Officers (all available to attend)	• Assess situation and call for back up, if required • Secure the area • Determines the need for police assistance. Calls (0-000), if required • Attempt to de-escalate and patient restraint, as required as determined by Medical Lead • Complete appropriate Security report
Medical Lead: **In hours:** CRMO ED Consultant/Fellow (for ED) **After hours:** Senior On Site ED Registrar (for ED)	• Initial medical response & prescription of medications as required • Authorise chemical/physical restraint for patient responses, as a last resort, as required • Responsible for ensuring the patient's airway is maintained, be alert to positional asphyxiation indications, prevent injury to hyper-flexed joints and ensure minimal force is used throughout the restraint • Ensure documentation is completed in the medical record • Notify admitting team and AMO if applicable
Mental Health: Mental Health CNC **0800-2230**	• Mental Health consultation • Assist with de-escalation

**HSFAC must be notified if the incident activates a Disaster. The trigger would be a serious incident with risk to staff e.g.: armed offender or evacuation of an area.*

Staff Responsibilities

All staff:

- Are required to complete training, in line with their roles
- Are to follow the procedures set out to keep themselves and others safe from the risk of violent behaviours
- Are to respond to incidents using violence preventions techniques including de-escalation and evasive techniques, in line with their training
- Call a Code Black if required, via 2222
- Participate in follow-up activities required to minimise the effects of these incidents, such as first aid (physical and psychological), incident debriefings, investigations and corrective actions
- Follow directions and assist the Code Black response team as directed

Code Black Contingency

Where a second Code Black (or other facility Emergency) is activated whilst the response team is already attending to a Code Black, the Response Team Leader is responsible for nominating the appropriate team members to be released to respond to the second call. The decision should be based on retaining Code Black members best suited to manage the current situation.

Use of Patient Restraint

SCHN is committed to principles of least restrictive practices, however staff safety is paramount. SCHN considers the use of restraint must be reserved for circumstances of the safety of patients, staff and others or critical need and only implemented when all other options have been explored. Physical restraint, following the Violence Prevention Management principles, is only used until the patient's behaviour is controlled with medication and it is safe to remove the restraints. Medications to use are identified in Appendix 4.

For more information, see SCHN Health Guideline: Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments.

Police

Dial 0-000 if you think police are required e.g.: incidents involving weapons, an armed person or hostage situation.

Code Black Stand Down

Following de-escalation of the situation and/or removal of any person exhibiting violent behaviour, the Code Black Response Team Leader will consult members of the Code Black Response team to agree on the need to stand down the Code Black and notify Switchboard to issue a Code Black stand down notification.

To stand down a Code Black

- Code Black Team Leader dial 2222 on an internal phone
- Advise Switchboard operator of:
  - Your name and title
  - Location of Code Black
  - Code Black stand down

Example:

This is Jane Smith, Patient Flow Manager.

Please issue a Code Black stand down: Sunny's Cafe

The **Switchboard operator** is responsible for:

- Issuing the Code Black stand down notification

Post Code Black Incident Management and Reporting

As soon as possible after the Code Black, an Incident Report Template is to be completed by the Hospital Incident Controller - Appendix 5.

Completion of an ims+ notification is to be completed by the NUM or Team Leader of the area as soon as practicable after the event in accordance with NSW Health Incident Management Policy (PD2020_047).

Post Incident Response – patients/family/carers

For a patient-related incident, the Medical Lead or allocated RN is responsible for providing documentation in the patient's health care record. The AMO is to be notified as soon as practicable.

To avoid the occurrence of future incidents, the NUM/Team Leader/Manager must ensure the patient's clinical team is notified of the incident and that the team reviews the patient's care plan. This may include a multidisciplinary review and should include the patient and their family/carer, to include/amend prevention strategies for managing identified stressors or stimuli that trigger behavioural escalation. This information is to be documented in the patient's eMR and communicated to relevant staff.

Post Incident Response – staff

Staff involved, whether directly or as witnesses, will react in different ways, regardless of the level of severity of the incident. It is important for managers to be sensitive to how a staff member wants to be supported, particularly immediately after the incident when some staff may prefer to be alone, rather than receiving more active assistance. For staff support – confidential support is available from Employee Assistance Program Converge International 1300 687 327 or ACCESS EAP 1800 818 728.

Manager/Team Leaders must:

- Ensure any injuries are treated
- Make certain the staff member is supported from the time of the incident
- Staff members should be provided with any necessary support during a period of vulnerability
- Ensure any witnesses to an incident are also offered appropriate support
- Be sensitive to how the incident is communicated to other staff. For example, a staff member may not want their experience repeatedly described, unless it is necessary for safety reasons
- Ensure the incident is reported on ims+

Post Incident Debrief

- When the Code Black is stood down, an immediate (hot) debrief is held and a further review (cold debrief) is held some days later
- The Hospital Incident Controller is responsible for ensuring the debriefs occur, including representatives from each area involved in the incident response

- The SCHN Disaster Coordinator is responsible for arranging the debriefs, relevant representation and documentation
- All staff involved in the response should be given the opportunity to provide written or verbal feedback.

Incident Review and Governance

An operational review is to be undertaken for each Code Black incident using the Incident Report Template (IRT) – see Appendix 5 and the report in ims+.

The level of review is determined by the severity of the incident. A preliminary risk assessment should be completed for clinical incidents. Concerns of continuing or serious risk of harm to patients, staff or visitors should be immediately escalated to the DCO/Exec on call/HSFAC (see NSW Health Incident Management Policy). The review of minor incidents may be completed locally. Where there has been a security risk to a unit or a site, if there is a prolonged threat or harm to a staff member, a formal review would be indicated.

This review will include any operational, environmental or logistical issues which arose during the Code Black response e.g.: response attendees, response time, coordination of roles, risk controls.

The outcome of the review will be tabled at the CHW Disaster Response Committee or the SCH Emergency Plan Committee for discussion, actions and recommendations to improve processes.

The HIC will identify who is to undertake the review. For minor incidents, this may be the manager of the area. For other incidents, a more senior member of staff will conduct the review (eg. CPD, HIC, DCO, DON).

SCHN Code Black Team Response Areas

Code Black response team members must provide an immediate response and should assemble at the nearest identified safe point close to the incident.

Sydney Children's Hospital:

The SCH Code Black response team responds to all areas that are designated SCH Buildings (see Appendix 2 for site map), as the primary responders for all Code Black incidents within these buildings:

- SCH Main Building (1A, 1B)
- SCH Emergency Wing (2A)
- SCH South West Wing
- Bright Alliance Building, Levels 7, 8 and 9

The SCH Code Black response team will respond to other areas within the Randwick Hospitals Campus if a paediatric response or assistance is required. The team should respond if they are unsure of the primary responding hospital.

The Children's Hospital at Westmead:

The CHW Code Black response team responds to the following areas:

(see Appendix 3 for site map)

- CHW Main building, including wards
- Linkway to K Block
- Child Care Centres
- Kids Research
- Children's Hospital Medical Centre
- External grounds/areas belonging to CHW

Legal Context for Management of Violence

Violence requires health professionals to be aware of the legal context and requirements for subsequent actions or interventions.

Doctrine of Necessity

The common law Doctrine of Necessity, sometimes referred to as 'Emergency Powers', is the mechanism that allows health professionals to intervene in the care and treatment of patients in the following circumstances:

- The treatment is necessary to prevent imminent serious injury or even death; and
- That treatment does not override a competent patient's wishes

NB: This should only be used in emergencies, not in a consistent or planned manner. When it is anticipated that the patient may require ongoing management (greater than 24 hours), legislative requirements should be enacted. For example; consideration may have to be given to a Mental Health Act Certificate (Mental Health Act 2007 (NSW)) in the context of mental disorder or mental illness; or a Guardianship Application (Guardianship Act 1987 (NSW)) in the context of impaired capacity.

Reasonable Force

There is no single definition for reasonable force, which is context specific and considered the amount of force necessary in any given situation. Professional judgment must be applied in any situation, commensurate with the presented risk. This judgment may be challenged by others and responders may be required to support why other courses of action were inappropriate for the situation.

Education / Training

The Code Black response must be regularly tested via drills and a record kept.
All staff must:

- be involved in drills or tabletop exercises
- be aware of how to raise the alarm
- be aware of how to wear and operate a duress alarm
- be aware of where to retreat to for safety
- be aware of specific local procedures e.g.: for home visiting/community work

The following categories of staff at SCHN have been identified to ensure training is provided in accordance with NSW Health policy Violence Prevention and Management Training Framework for NSW Health Organisations (PD2017_043).

Staff Categories	Minimum training Requirements
Staff working in clinical areas	HETI Modules Violence Prevention and Management Awareness (Course code 39831935) Violence Prevention and Management – Promoting Acceptable Behaviour in the Workplace (Course code 39964553)
Staff identified as working in high risk areas, eg: ED, Mental Health units	Violence Prevention and Management – An Introduction to Legal and Ethical Issues (Course code 39964595) Personal Safety training (1 day course)
Staff identified as potentially involved with the physical restraint of other individuals eg: ED, Security, Mental Health units	Team Restraint Techniques Training or Emergency Department Violence Prevention and Management Program (EDVPM). Mental Health and Security staff to attend 3 day VPM
Staff Managers	Managers are required to: Understand their responsibilities in preventing violence risk prevention, management and control Ensure staff training needs are identified and documented and that staff are rostered to attend training Develop procedures, in consultation with staff, to control or eliminate workplace violence Manage incidents in accordance with Incident Management Policy (PD2020_47), including post incident staff monitoring and support

Supporting Documentation

The Code Black incident is to be recorded as follows:

- ims+
- Incident Reporting Template (IRT) – Appendix 5
- Patient eMR (where applicable)

Related Policies / Procedures / Guidelines / Business Rules

1. Randwick Campus Emergency Planning Committee. Randwick Hospitals Campus Emergency Plan, 2015.
2. SCHN Code Black Six Minute Intensive Training (SMIT) (Appendix 7)
3. Security Incident Requiring Controlled Hospital Access – CHW Policy
4. NSW Ministry of Health (2022). Protecting People and Property Manual.
5. NSW Ministry of Health. (2017) Violence Prevention and Management Training Framework for NSW Health Organisations (PD2017_043).
6. NSW Health (2015). Management of Patient with Acute Severe Behavioural Disturbance in Emergency Departments. (GL2015_007).
7. NSW Ministry of Health (2020). Incident Management Policy. (PD2020_047). December, 2020.
8. NSW Health (2015). Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach (PD2015_001).
9. SESLHDPR/322. Health, Safety and Wellbeing Incident Investigation. July, 2022.

Appendix 1: Description of Offender Form

PERSONAL DESCRIPTION OF OFFENDER

_____

_____

_____

_____

NOTES FOR COMPILATION

A separate form required for each person. To be compiled immediately after incident by each staff member, also bystanders if possible. Please circle as applicable.

If answer is unknown write UK against heading. Do not consult with others during compilation. Senior officer to collect forms and hand to the police.

NAME OR NICKNAME USED _____

APPROXIMATE AGE_____

HEIGHT_____

COMPLEXION fair dark pale fresh
ruddy suntanned pimply

ACCENT_____

POSTURE erect stooped slouched

WALK quick springy slow limp
pigeon-toed

HAIR colour _____
straight wavy bald curly
thick long crew-cut

EYES colour _____
size S M L other:
intense stare squint

EARS shape_____
size S M L other:

NOSE shape _____
size S M L other:

LIPS shape _____
size S M L other:

TEETH good uneven spaced missing
bad protruding

CLOTHING include hat, tie, shirt, coat, trousers, dress, skirt, sweater and shoes.

_____

_____

SEX male female

ETHNIC ORIGIN _____

WEIGHT _____

BUILD thin stout medium nuggetty

VOICE clear loud thick slangy

SPECTACLES colour _____ shape _____
thick glass_____ tinted _____

MOUSTACHE – BEARD type _____

DISGUISE _____

HANDS calloused soft hairy nails missing
deformed fingers size S M L other:

GLOVES type _____ colour _____

JEWELLERY describe _____

SCARS OR MARKS tattoos, scars, discolourations, describe location fully _____

_____

MODE OF OPERATION – what did the offender do, say, touch, carry etc. _____

_____

WEAPON TYPE _____

METHOD AND DIRECTION OF ESCAPE _____

_____

Make and model of car _____

Registration _____

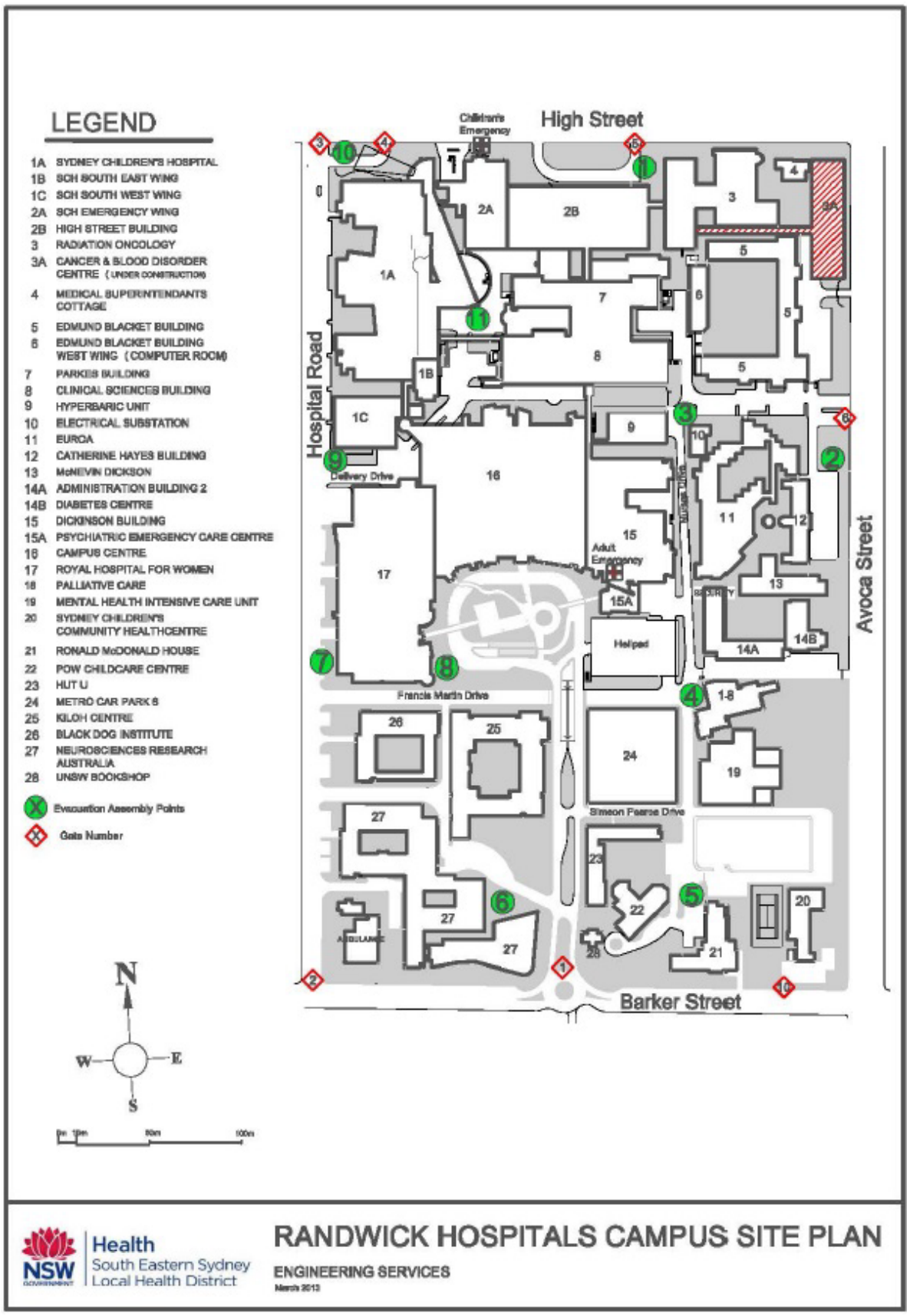
Colour _____

Number of vehicles used _____

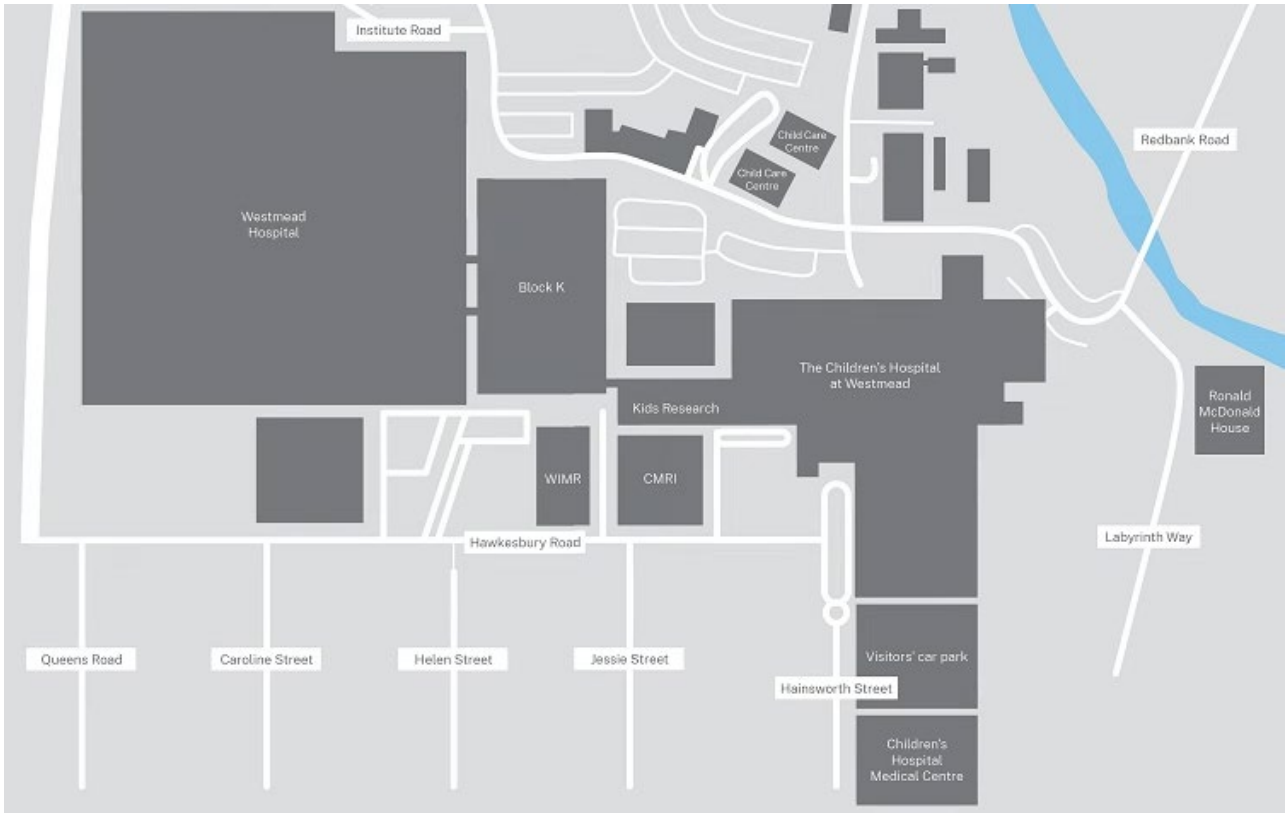
SIGNATURE _____

ADDRESS _____

Appendix 2: Randwick Hospitals Campus Site Plan

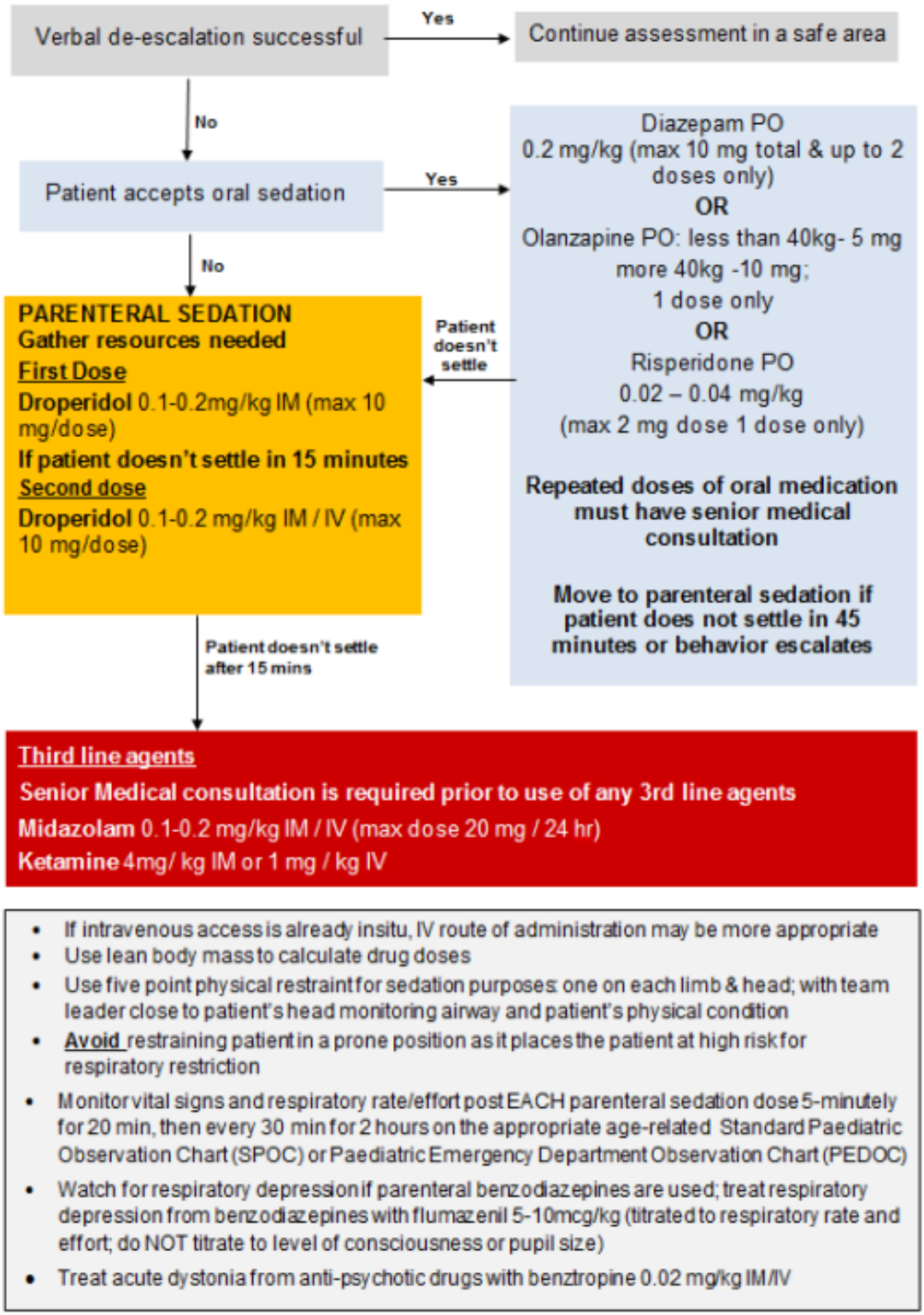


Appendix 3 Westmead Precinct Site Plan



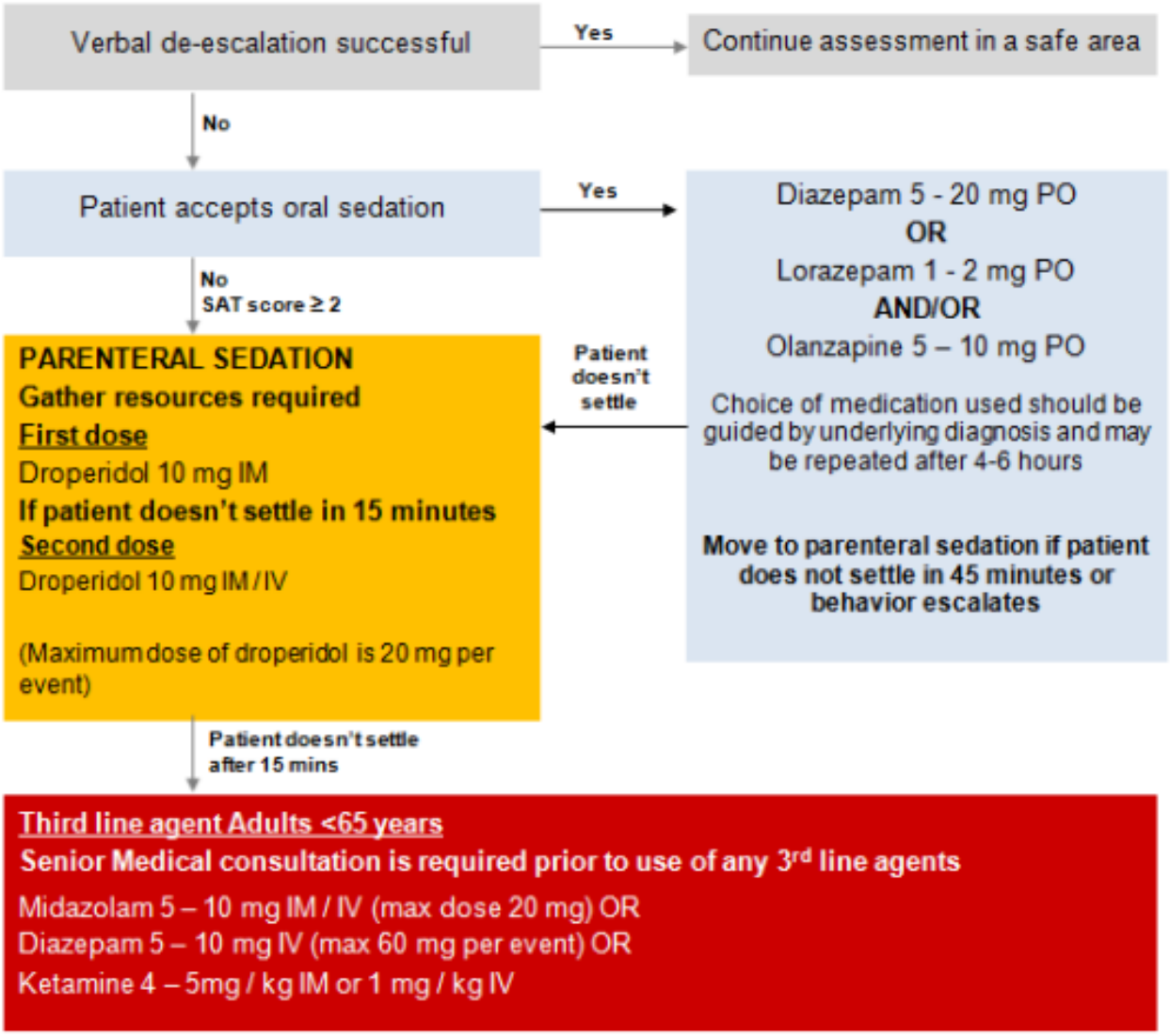
Appendix 4 Paediatric and Adult Sedation Flowcharts

Paediatric (under 16 years) sedation algorithm for patients with acute severe behavioural disturbance in the Emergency Department



- If intravenous access is already insitu, IV route of administration may be more appropriate
- Use lean body mass to calculate drug doses
- Use five point physical restraint for sedation purposes: one on each limb & head; with team leader close to patient's head monitoring airway and patient's physical condition
- Avoid restraining patient in a prone position as it places the patient at high risk for respiratory restriction
- Monitor vital signs and respiratory rate/effort post EACH parenteral sedation dose 5-minutely for 20 min, then every 30 min for 2 hours on the appropriate age-related Standard Paediatric Observation Chart (SPOC) or Paediatric Emergency Department Observation Chart (PEDOC)
- Watch for respiratory depression if parenteral benzodiazepines are used; treat respiratory depression from benzodiazepines with flumazenil 5-10mcg/kg (titrated to respiratory rate and effort; do NOT titrate to level of consciousness or pupil size)
- Treat acute dystonia from anti-psychotic drugs with benztropine 0.02 mg/kg IM/IV

Adult (under 65 years or no diagnosis of organic cognitive impairment) sedation algorithm for patients with acute severe behavioural disturbance in the Emergency Department



- If intravenous access is already insitu, IV route of administration may be more appropriate
- Use five point physical restraint for sedation purposes: one on each limb & head with team leader close to patient's head monitoring airway and patient's physical condition
- **Avoid** restraining patient in a prone position as it places the patient at high risk for respiratory restriction
- Aim for Sedation Assessment Tool (SAT - see section 6.2 in Guideline) score 0 or -1 or -2
- Continuous pulse oximetry & close observation is recommended in all patients until they are able to respond to verbal stimuli. Monitor vital signs and SAT score post EACH parenteral sedation dose 5 minutely for 20 min, then every 30 min for 2 hours
- Urgent clinical review by senior medical officer if parenteral benzodiazepines are used & respiratory depression noted (e.g. SpO2 < 95%, RR < 12 or patient appears poorly perfused)
- Benztropine 1-2 mg IM / IV may be given for acute dystonic reaction.

Appendix 5 SCHN Incident Report template

To be completed by member of the IRT flowing all incidents (excluding Code Blue). The report is to be forwarded to the relevant internal external email distribution list and to the managers of the areas affected by the incident.

Type of incident:	☐ Red	☐ Purple	☐ Yellow	☐ Black	☐ Orange	☐ Brown
Date and Time of Incident:						
Location of Incident:						
Individuals notified by:						
Individual/s responded:						

Incident Summary

Actions Taken

Incident Escalated to HDC/Exec on Call:	

Stand Down:	

Identified actions to be followed up:

Report submitted:

Date	**Name**	**Position:**

Manager notified:	

IMS+ completed:	

Debrief/Outcomes of follow up:

Incident closed

Date:	**Name**	**Position:**

Appendix 6 Team Response Card

Code Black Responder	Responsibilities
Hospital Incident Controller (HIC): **Nurse Manager Patient Flow** (or Delegate) (in hours) **After Hours Nurse Manager** (AHNM) (after hours)	• Assume incident control role as Code Black Response team leader • Escalate any further response that is required • Consider informing Campus or Precinct partners • Inform CPD/DCO/Executive on Call/HSFAC*, as relevant, of any issues or if further escalation or response is required e.g.: decision to lock down or evacuate (Code Orange) • Determine stand-down of the response • Inform Switchboard operator of Code Black stand down • Complete SCHN Incident Report Template – Appendix 5 • Identify person responsible for conducting incident review
NM /NUM /Team Leader/ Manager (for incident occurring in ward/unit/department)	• Patient and/or situation assessment, de-escalation if appropriate • Notification to medical team for attendance as a rapid response • Documentation of events in medical record • Complete ims+ notification • Advise parent or guardian of patient-related incident
Security Officers (all available to attend)	• Assess situation and call for back up, if required • Secure the area • Determines the need for police assistance. Calls (0-000), if required • Attempt to de-escalate and patient restraint, as required as determined by Medical Lead • Complete appropriate Security report
Medical Lead: **In hours:** CRMO ED Consultant/Fellow (for ED) **After hours:** Senior On Site ED Registrar (for ED)	• Initial medical response & prescription of medications as required • Authorise chemical/physical restraint for patient responses, as a last resort, as required • Responsible for ensuring the patient's airway is maintained, be alert to positional asphyxiation indications, prevent injury to hyper-flexed joints and ensure minimal force is used throughout the restraint • Ensure documentation is completed in the medical record • Notify admitting team and AMO if applicable
Mental Health: Mental Health CNC **0800-2230**	• Mental Health consultation • Assist with de-escalation

**HSFAC must be notified if the incident activates a Disaster. The trigger would be a serious incident with risk to staff e.g.: armed offender or evacuation of an area.*

Appendix 7 SCHN Code Black Six Minute Intensive Training (SMIT)

CODE BLACK: PERSONAL THREAT

Take 5 minutes to find out more

What is a Code Black?

A Code Black is a personal threat including armed or unarmed confrontation where a person's behaviour is threatening to themselves, others or property.

What do you do?

- Remain calm
- Retreat and remove yourself and others from danger
- Raise the alarm: Call 2222
- Do not attempt any action that may put yourself or others in further danger
- Wait for help to arrive
- Follow the directions on Emergency Procedures Flipchart

Notification Cascade

Decision to activate Code Black

↓

Call 2222

↓

Code Black team responds

Who will respond to a Code Black?

When a Code Black is activated, the Code Black Team, including Security, will attend the location of the incident.

The Code Black Team includes Security, medical, management and mental health staff members.

If the situation is severe, it may also be necessary to call the Police: 0-000.

What you can expect of the Code Black Team

The Code Black team will incorporate their multidisciplinary expertise in assessing and intervening where needed to increase the safety of staff, patients and visitors.

Points to remember!

- Know your plan before you need it
- Know the internal emergency number: 2222
- Take reasonable action to keep yourself and others safe

Appendix 8 Code Black Team Allocation Template

- Code Black Team members must be identified and recorded by the AHNM at the start of each shift
- Team members must be able to immediately cease their duties to respond when needed
- Roles must be defined at the commencement of each shift
  Any vacancy (eg sick leave) needs to be identified and filled.
- If members of the team are not available for the whole shift (eg on different shift patterns) or cannot continue in the team for the whole shift (eg allocated duties that cannot be immediately ceased or is sick/injured), replacement workers must be identified

Code Black Response Team Members:

Record team members at the start of each shift.

Shift A (add/delete shifts as required)		**Date:**
Name	Role in the Response Team	Position

Shift B (add/delete shifts as required)		**Date:**
Name	Role in the Response Team	Position