Violence experienced by healthcare workers in Ontario: an exploration of the reasons for the high incidence and measures that might be taken to curb it

***James T. Brophy, PhD**, (Visiting Researcher, Occupational and Environmental Health Group, University of Stirling), **Margaret M. Keith, PhD**, (Visiting Researcher, Occupational and Environmental Health Group, University of Stirling), and **Michael Hurley** (President, Ontario Council of Hospital Unions/Canadian Union of Public Employees)*

SUMMARY OF RESEARCH

Many healthcare workers in Ontario face the threat of violence with every shift. Studies have found that nurses, for example, are subjected to more acts of violence than police officers or prison guards.[i] A survey of paramedics in Ontario and Nova Scotia found that 75% had experienced violence in the previous year; 67% were verbally assaulted; 26% had been subjected to physical assault.[ii] Ontario compensation board statistics show that "in 2014, lost-time injuries due to workplace violence in the healthcare sector greatly outnumbered those in other sectors surveyed".[iii]

The Ontario Council of Hospital Unions (OCHU)/Canadian Union of Public Employees (CUPE) has undertaken a series of research initiatives to examine their members' experiences of violence on the job. All of the 150 registered practical nurses (RPNs) from across Ontario attending a conference on violence in Kingston in January, 2016, reported that they had experienced violence at work.[iv] A telephone survey of healthcare workers in North Bay, Ontario revealed that 60% of all respondents (n=74), which included both direct patient care and auxiliary workers, had experienced physical violence in the past year; in the subset of nurses and personal support workers (n=44) 85% had experienced physical violence, 88% had experienced non-physical violence, and 64% had experienced sexual harassment or assault.[v]

The acceptance of violence in healthcare settings as part of the job seems to be rooted in cultural, economic and political dynamics.[vi] Violence permeates all aspects of our society. Violence against women remains a widespread systemic social problem, resulting in injury, death, emotional trauma, and insecurity. In Canada, the majority of healthcare workers are women. Whether because of the gender make-up of the workforce or the widespread nature of violence against women in our culture, workplace violence is a significant problem for women working in healthcare. The International Council of Nurses reported that, "Nurses are the healthcare workers most at risk, with female nurses considered the most vulnerable."[vii] Somehow, we -- and the society around us -- have come to see violence in healthcare as *normal* or as *unavoidable*. Violence, in all its forms and degrees of severity, is viewed as an inevitable risk.[viii] But comparative studies of various countries show that strategies can be employed to reduce or eliminate the threat of violence. For example, a study of violence in long-term care facilities found that Canadian healthcare workers experience 6 times more incidents of physical violence than their counterparts in Scandinavian countries.[ix,x] The authors of the comparative study said workers were

experiencing "structural violence," which they blame on "systemic and organizational factors" such as poor working conditions and lack of adequate support.

When it comes to protection of healthcare workers, Canadian jurisdictions are lacking. OCHU/CUPE partnered with academic researchers associated with the University of Stirling to try to understand why workers in Ontario's healthcare facilities face such a high level of violence and what solutions are needed. The facilitator team included two academic health and safety researchers affiliated with the University of Stirling who conducted the interviews and analyzed the information they gathered. It also included a nurse and member of OCHU/CUPE who was granted a research fellowship by the host university to recruit participants, organize dates and locations and record interviews. Between June and September, 2016, the facilitators conducted thirteen group interviews with fifty-four healthcare workers in seven communities to identify:

(1) workers' perceptions of the risks to themselves and their co-workers of being subjected to violence on the job;

(2) what barriers, if any, exist to addressing the incidence of violence as described in the literature;

(3) whether any recommendations can be formulated for use by a range of bodies such as governments, regulatory agencies, administration and employee bodies that may reduce the incidence of violence perpetrated against healthcare workers.

Overall, the researchers consulted with 27 registered practical nurses (RPNs), 6 personal support workers (PSWs), 9 administrative and related staff, 5 cleaners/housekeeper, 3 dietary staff, 2 personal care assistants (PCAs), 1 physiotherapy assistant, and 1 maintenance staff. 41 interviewees were women and 13 were men. They worked in either general hospitals, long-term care, forensic or detoxification centres and had work experiences in a wide range of departments.

They provided a wealth of knowledge. The work experience of all of the participants totaled 1,153 years. Although there was a wide range of age between the youngest interviewee at 23 and oldest worker at 65, the average age was 47 years. The average individual work experience was 21 years. All but one of the participants, a dietary staff person, had personally experienced violence – most on a regular basis. All had witnessed numerous episodes.

The European Agency for Safety and Health at Work states there is no uniform definition for workplace violence. However, it is generally agreed that, *"Violence is a generic term that covers all kinds of abuse including 'homicide, assault, threats, mobbing and bullying; in effect, all behaviour that humiliates, degrades or damages a person's well-being, value and dignity.'"*[8] The American Academy of Experts in Traumatic Stress (AAETS) includes *"near misses"* and *"fear of assault or witnessing an assault on a co-worker"* in their definition.[xi]

The study was designed primarily to explore Type II violence, which is defined by the Public Services Health and Safety Association of Ontario as "physical or verbal assault of an employee by a client/family member or customer."[xii] There were, however some incidents of Type III co-worker violence described. Because violence of any kind can have negative effects, the study covers the full continuum of violence, ranging from negative verbal comments to serious physical assault.

The following is a brief summary of the information gathered during the group interviews. One of the overall findings was that violence is a universal problem throughout Ontario's healthcare facilities. It was also revealed that here are considerable inconsistencies in risks from one community, facility or department to another as well as significant differences in protections provided. A few participant comments have been included to illustrate key points. (Some comments have been edited for clarity or confidentiality.)

FACTORS THAT CONTRIBUTE TO VIOLENCE

The study's participants identified numerous factors that contribute to violence against healthcare workers. They are grouped in this report using the following US Occupational Safety and Health Administration (OSHA) categories: *Clinical, Environmental, Organizational, Social,* and *Economic.*[xiii]

Clinical Risk Factors

Clinical risk factors include "the influence of drugs or alcohol; severe pain; history of violence; cognitive impairment (e.g. dementia); and certain psychiatric diagnoses."[13]

Many study participants described violent incidents from patients whose judgment was apparently compromised by the use of drugs, alcohol or by dementia, extreme pain, or mental illness. Many of these incidents took place in long-term care and geriatric care departments, psychiatric units, detox facilities, forensic units and emergency departments – all of which have been shown in published studies to be areas of highest risk. But many also took place on general wards, medical/surgical departments, day surgery, internal medicine and stroke care departments.

> *"We need appropriate funding for people to be placed where they should be, not where they shouldn't be. You have patients with drug problems. They need to have a place other than the hospital where they can take them."*

A study participant described a very violent incident in which a mentally ill patient in drug withdrawal launched an unexpected and very vicious attack that resulted in serious injury to the worker. Another described an incident in which the patient, who unbeknownst to the study participant had a history of mental illness and violent behaviour, launched a vicious attack resulting in a serious concussion.

Environmental Risk Factors

Environmental risk factors "relate to the physical layout, design, and contents of the workplace." These include such building features as "unsecured access/egress into or throughout the facility; insufficient heating or cooling; irritating noise levels; unsecured items, such as furniture that can be used as weapons; and lack of personal security alarms that permit staff the ability to respond appropriately to workplace violence incidents."[13]

Participants told us the building design was often not protective allowing for patients to trap workers in corners or behind doors. Participants described situations in which they had been trapped in a room by an aggressive patient and had been unable to call or signal for help.

Many nursing stations were considered unsafe because they did not have protective shatterproof glass or plastic barriers or adequate egress options.

Some of the participants said they were issued personal security alarms and many were not. Even those who had alarms could not depend on a quick response.

> *"He got aggressive with a PSW . . . I went out to protect her and was able to redirect him to me. So the incident lasted approximately half an hour. . . . I wasn't able to call a code white or for extra help because he had a hold of both of my arms. And the more I tried to get away, the stronger he got. So it was really a push and pull and tug. He slammed me against some walls and pushed me down on the bed. Eventually, two PSWs came to help me and . . . we ended up being on the other side of the door holding the door closed. And he was turning the handle to open the door but not pushing it or pulling it open. So we were able to hold the door shut. . . .That's when we called for help."*

Some had been hurt when patients used furniture, commodes, dishes or other objects as weapons.

Some nursing stations had protective barriers while others did not. They spoke of patients grabbing items from the nursing station and throwing them or jumping over the barrier to attack an unprotected worker.

> *"This is when he grabbed me and hit me with the glass. I slumped to the ground and he was still pounding me. . . . And next thing you know, all I can tell you I remember -- I don't remember being on the floor -- but I remember my tongue being tingly and then my memory was off . . . I fought him all the way down the hall. He put my head through the wall. There was blood on the walls from my elbows, my face."*

Organizational Risk Factors
Organizational risk factors for violence in healthcare facilities are the "policies, procedures, and prevailing culture of the organization related to safety and security."[13]

The study's participants identified many factors that could be considered organizational including: working alone or short-staffed; lack of trained security personnel; healthcare workers responsibilities during *Code Whites;* inadequacy of de-escalation and other training; under-reporting; limited use restraints; inadequate number of seclusion rooms. In some locations, police have a practice of bringing violent patients into the healthcare setting without adequate controls.

The issue of inadequate staffing levels was heard in every group in every locations.

Many also said they did not regularly file incident reports due to time-constraints, being discouraged by management and co-workers to do so, and the difficulty and complexity of report forms and computer programs.

> *"When you're short staffed and there's no time to do incident reports -- it's like they make the incident reports so difficult for you to weave through, it just becomes too much to do and there's no time to do it – so no one ever does it."*

There is a lack of communication regarding potentially violent situations between various staff. For example, PSWs may not be included in nursing care huddles or have access to a patient's medical chart.

There is inconsistent flagging of potentially violent patients, not only in their chart, but other visible locations.

Social Risk Factors
Social factors include the use of "weapons among patients and their visitors; the increasing use of healthcare facilities by authorities as criminal holds; and presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members."[13] Social risk factors also includes societal attitudes towards racial and sexual minorities and women.

> *"She came in with the police, wasn't searched by the police or anything. She was homicidal, suicidal, and when my friend got over there, they were trying to get her into key locks [restraints] because she was throwing stuff at them, she was threatening people. Nobody checked her, nobody patted her down. It turned out she had a six-inch blade on her."*

Several healthcare workers said they had experienced a decrease in respect from patients and visitors in the past few years. Others said management and other healthcare professionals, such as doctors, treated them with disrespect. When there is little respect, there is a greater

likelihood of verbal and physical abuse. Furthermore, some participants said that their supervisors did not encourage respect for them.

In some facilities, signs have been posted telling patients and visitors there is "Zero Tolerance" for abusive behaviours. Others have no such signage.

"A patient referred to the nurses as whores and bitches. Whore number one, whore number two, bitch number one, bitch number two"

Discrimination was cited as a trigger for violence, ranging from verbal insults to sexual harassment and assault. Some participants said they were particularly targeted because of their race, gender or sexual orientation. Many of the women said patients had sexually abused them -- verbally and/or physically.

"I know the sexual harassment stuff is definitely a problem for women healthcare workers. If I go in with a male healthcare worker, the patient is not going to pinch his butt. They're going to pinch mine or make a sexual comment. And again, unfortunately, because he has dementia, he's just a 'part of the job" kind of deal. Now, if I had a 20-year old do that to me, which has happened, it would not be considered appropriate. But it's more the elderly dementia patients."

Cultural and racial differences have also become a flash point for some patients.

Distraught families and traumatized patients sometimes lash out at healthcare workers – verbally or physically -- blaming them for the patients' discomfort, waits, etc.

"He was angry over a bruise on his mother's hand, which we had suspected was from basic blood work. He was chasing the healthcare aide, barricading her. I grabbed his attention and opened the unit door and yelled, 'You need to leave now. You can't do this, you need to leave.' Then he starts chasing me."

Economic Risk Factors

Economic risk factors are related to the funding levels of the institutions and decisions regarding allocation of funds, which "can contribute to risk factors on a personal level in the form of stress levels and on an organizational level in the form of short staffing."[13]

The participants, without exception, identified limited resources as a contributing factor to violence**.**

> *"Sometimes the nursing staff just does not have enough hours. It's a matter of just giving the patient the meds and getting out. They have cut so far. Sometimes patients don't just need meds. They need someone to come in and say, 'How is your day going?' You know, sit for five minutes and talk to this patient for their mental wellbeing, to make them feel better. They've cut so badly."*

Participants reported that under staffing contributes to patient frustration, boredom, fear and anger, which can then lead to acting out behaviours. They spoke of the problems associated with short staffing when workers who called in sick where not replaced.

In some cases, the staff placement was inappropriate, e.g. assigning a new graduate to a potentially volatile patient without additional staff support.

Lack of funding contributes to many of the factors that can increase the risk of patient aggression towards healthcare staff.

There was concern expressed that the increase in public-private partnerships (P3) would further erode hospital staffing levels and, in turn patient care and staff safety.

> *"You know, they're talking about not having enough funding. But the healthcare system is becoming a profit-making system."*

They also said there has been a reduction in the number of therapeutic programs for mental health and long-term care patients, which were designed to calm and reassure patients.

They spoke of inappropriate prioritizing by management of the limited funds within the institution's budget.

EFFECTS ON HEALTHCARE WORKERS

Violence can have serious physical repercussions as well as emotional and mental health effects. It can also have financial consequences. Even witnessing a violent incident can have profound, long-term effects as can the fear of violence. Families and friends may suffer along with the victims.

Participants described: physical injuries ranging from relatively minor to very serious. Some have sustained chronic or permanent injuries.

Some described the life-altering impact of suffering from post-traumatic stress disorder (PTSD) after an assault. Others had symptoms of cumulative stress. In some cases the physical or mental effects have significantly impacted their relationships and family lives.

> *"She never returned to the hospital, and she had great difficulties. . . . And then she was cut off WSIB [compensation]."*

They talked about the trauma of witnessing violence; of feeling violated; being fearful; never feeling safe; feeling hopeless. Some quit or considered quitting their jobs or leaving their professions.

They told of taking their stress and fear home and the impact it had on their personal and family lives.

More experienced healthcare workers described the change in their role over the past decade or so – from caregiver to ad hoc security personnel – particularly during Code Whites. They believe it affects their care giver-patient relationships and makes them feel professionally less effective. Some nurses expressed fear of losing their license because of the nature of the interactions with violent patients.

They spoke of a lack of support from management and a lack of acknowledgment of their injuries, including PTSD, which compounded the negative effects they were already experiencing.

> *"I can't do enough for them during the day and it makes me feel like I'm a horrible nurse at the end of the day. It makes me feel like my license is on the line, not because I'm not competent, but because I should have done more and there's not enough time because there's not enough staff. The violence, it totally escalates when there's not enough staff."*

BARRIERS TO ACHIEVING PROTECTIONS

There were numerous barriers identified to eliminating violence. Study participants reported that violence has become normalized in many healthcare settings. Some felt that it is being increasingly viewed as "part of the job." Some expressed concern that it may be impossible to eliminate the threat of violence. This sense of hopelessness or defeat may be a significant barrier to dealing with violence. In situations where management regularly dismisses acts of violence as insignificant, there may be a lack of inducement within the institution to implement effective policies and changes.

Another thorny issue is that patients with dementia or mental health issues are often considered not criminally responsible (NCR) for acts of aggression. As a result, police are

often not called and criminal charges are not consistently laid or upheld. This may send a signal to patients that violence will have no consequences.

Another barrier is the apparent conflict between what is considered "patient rights" and "worker rights." For example, facilities now have "least restraint" policies in place but have not increased staff or other protections.

As mentioned, there are barriers to reporting violent incidences. Participants said that the reporting procedure is not encouraged and is very time consuming and onerous. Some fear reprisals for filing reports. Others expressed that they felt it would make no difference to report.

The fact that healthcare workers are not permitted to speak publicly about the issue of violence results in a lack of public awareness of this failing within the healthcare system. Some of the same factors that result in violence against healthcare workers also affect the quality of patient care – a concern for everyone.

> *"Violent occurrences are made light of by management. I've seen the comments . . . It's accepted – it's part of the job. That's exactly it - - it is part of your duties. If you don't like it maybe you should look at a different type of job in a different type of field."*

The inconsistency of budgets and chronic lack of adequate healthcare funding is a significant barrier to implementing protections, such as adequate staffing, programs, engineering controls, environmental design, security measures, etc.

There are inadequate regulatory and legislative protections to prevent violence. There are also significant inconsistencies in protection from one facility to another across the province.

Violence within healthcare settings reflects a broader cultural discrimination and disregard for women, minorities, racialized workers, and those with different sexual orientation and genders.

Divisions and hierarchies within the workforce further hinder efforts to make hospitals safer for all workers.

The failure of the Workplace Safety and Insurance Board (WSIB) to recognize many of the physical and psychological effects of violence further contributes to under recognition of such serious conditions as PTSD, occupational stress, and long term effects of concussion.

SOLUTIONS

The solutions to violence against healthcare workers are wide ranging. Each of the factors contributing to violence reported under the headings of: *clinical, environmental, organizational, social,* and *economic* require immediate attention. Participants offered the following solutions:

- Increase staff and replace workers who have called in sick.
- Develop simpler reporting procedures and provide time to enter information.
- Report all incidents regardless of severity or injury.
- Report all hazardous situations.
- Redesign the work environment to eliminate danger areas, to permit better supervision of patients, reduce noise, improve atmosphere to reduce patient anxiety and frustration, secure furniture and other potential "weapons," provide safe rooms and egress options, and install protective barriers at nursing stations, etc.
- Increase security personnel at higher levels of training and capacity to intervene with violent individuals and/or increase health care staff with specialized training to deal with violence.
- Provide all frontline healthcare workers with personal alarms and ensure that other stationary alarms are available and functional.
- Provide practical training for staff in dealing with threatening or violent patients.
- Provide programs for patients to reduce stress, fear, boredom, frustration, anger.
- Provide translators and cultural sensitivity training.
- Establish and enforce meaningful *Zero Tolerance* policies and install signage.
- Reassign *Code White* responsibilities to trained security.
- Lay criminal charges against perpetrators.
- Provide province wide access to charts flagging violent behaviours.
- Flag potentially violent patients in chart and a visible area.
- Place patients with mental health, addiction and criminal backgrounds in appropriate areas and facilities.
- Appropriately assign staff, i.e. need training and experience to handle challenging or potentially violent patients.
- Give healthcare workers more options and decision-making power regarding the use of restraints when needed.
- Ensure that seclusion rooms are available for use when needed.

- Increase efforts to gain public and media attention by publicizing incidents of violent behaviour.
- Make it mandatory for the Joint Occupational Safety and Health Committee (JOSH) to investigate and made recommendations if needed for any violent incident resulting in injury or near injury.
- Require mandatory reporting to the Ministry of Labour of any violent incident resulting in injury or near injury.
- Provide support for workers who have been assaulted (including time off, counseling if needed and WSIB.)
- Increase management, doctor, and co-worker RESPECT for ALL healthcare workers, which in turn will send a message to patients and visitors.

KEY RECOMMENDATIONS REGARDING THE HEALTHCARE SYSTEM IN RELATION TO VIOLENCE PREVENTION

Based on the information provided by the study participants as well as from published literature, the researchers support the solutions provided above and make the following key recommendations:

- Increase healthcare funding and staffing in Ontario to at least the Canadian average.

- Enact legislation that specifically criminalizes violence against healthcare workers.

- Healthcare workers should not be penalized for speaking publicly about violence while recognizing that care must be taken to protect individual patient confidentiality. Protective "Whistleblower" legislation for healthcare workers should be enshrined in the law.

- Every healthcare facility in Ontario should enact and enforce a "Zero Tolerance" policy regarding violence against staff. This should include appropriate consequences – including criminal charges were applicable -- for anyone who violates the policy.

- Healthcare workers should be encouraged to file ***Incident Reports*** for ALL violent incidents – including verbal. Reporting should be simplified – especially for minor incidents -- and work time should be permitted for this important function. All incident reports must be shared with the union.

- Healthcare workers should be encouraged to file ***Hazard Reports*** for conditions they perceive to put themselves and others at risk of violence (including inadequate staffing levels or inappropriate placements, lack of resources, lack of

trained security personnel, lack of alarms, poor building design, etc.) All hazard reports must be shared with the union.

- Healthcare workers should not be penalized for communicating to patients and their family members that they are temporarily working short-staffed when they are being blamed for the impacts short-staffing has on waiting times or care levels.

- Adequate in-person training should be provided on a regular basis to better equip workers to recognize warning signs of potential violence or conditions that might lead to violence as well as providing them with training on the most effective methods to de-escalate violence and to protect themselves.

- The current practices for handling of Code Whites needs to be reconsidered. Trained security personnel and/or designated and specially trained healthcare staff should be available to respond in a timely and reliable manner.

- Consistent province wide protections need to be legislated. In addition, policies need to be developed in each facility as part of their violence prevention programs that incorporate province-wide protections as well as additional protections that reflect the particular character and needs of the facility and community.

- Stakeholders – including the public and other healthcare unions – should be engaged in discussions about the health of the healthcare system. Is it meeting their needs? Do more resources need to go into it? What should the future of healthcare look like? What can the public do to help reduce or eliminate violence in healthcare facilities?

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