CANADIAN FEDERATION OF NURSES UNIONS
LA FÉDÉRATION CANADIENNE DES SYNDICATS D'INFIRMIÈRES ET INFIRMIERS

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Study

on

Violence Faced by Health Care Workers

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INTRODUCTION

The Canadian Federation of Nurses Unions (CFNU) represents almost 200,000 frontline nurses and nursing students across Canada, working in hospitals, the community, home care and long-term care. We are the collective voice of frontline nurses who provide hands-on nursing care.

Over the past two decades, as nurses we have experienced an increase in violence in our workplaces. Every day we go to work knowing that we may be verbally or physically abused. Nurses in every health care sector are being punched, kicked, spat on and sworn at. According to CFNU's survey of our membership, 61% of nurses reported a serious problem with violence over a 12-month period, including verbal abuse, racial or sexual harassment and physical assault. Most violence against health care workers is perpetrated by patients and their families. As high as these figures are, we know that most health care violence goes unreported.[1] It is the CFNU's position that all health care workers should have a right to work in safe workplaces which are free from all forms of violence – whatever the form and whatever the source.

It's a pressure cooker out there for nurses on the front line. Higher patient populations, greater patient acuity and increased workloads are all on the rise, and the quality of care is declining. Across the country, there are headlines about hallway nursing, forced overtime, nurse shortages and long-term staff vacancies. As a result, there have been emergency room closures, bed closures, delayed surgeries and a myriad of other issues. Violence is a symptom of this unhealthy work environment. In health care workplaces, violence has been normalized.

The situation in hospitals is particularly acute in emergency departments and in psychiatric facilities. Since anyone can wander in off the street into an emergency department, where patients are under stress and frequently in pain, facing long wait times, there is a significant potential for violence. Armed police may also bring in individuals who have been involved in altercations, are high on drugs or have mental health issues, and then leave them with staff, sometimes at facilities not designated for this purpose. Psychiatric facilities or departments, where patients are suffering from mental health disorders, is another setting where there is a high potential for violence. Finally, in long-term care, where staffing has not kept pace with the numbers of residents, nor with their rising acuity levels, it has been found that 90% of frontline care workers experienced physical violence from residents or their relatives, with 43% reporting physical violence on a daily basis.[2] Perhaps not surprisingly, one provincial report noted that the long-term care sector had a disproportionate number of violence-related lost-time claims, when compared to the hospital sector, which had at least three times as many employees (115 violence-related claims in LTC in 2013, compared to 81 in hospitals).[3]

This stressful environment contributes to nurse absenteeism (own illness or disability): 9.0% for full-time public sector health care nurses in 2016, compared to an average of 5.7% for other occupations. In 2016, the annual cost of nurse absenteeism due to own illness or disability was conservatively estimated at $989 million.[4]

As nurses, we are committed to caring for our patients, to helping them get well. However, when we experience violence, and the related physical and psychological impacts, it affects our ability to deliver quality care. Violence contributes to burnout, compassion fatigue, depression and anxiety, as well as PTSD symptoms, all of which erode our ability as nurses to provide quality care and safeguard the health

and well-being of our patients. For example, one nursing union has found that 25% of its membership consistently experience PTSD symptoms.[5]

As Justice Archie Campbell, who led the SARS Commission in Ontario, reminded us, if workers aren't safe, neither are patients.[6] If the mining industry can enforce strict OH&S standards to safeguard workers safety and drastically reduce the number of injuries, then we as nurses also deserve workplaces that take a similar approach to workplace safety with zero tolerance of violence. Currently, when compared to traditional male-dominated occupations – mining, construction and manufacturing, for example – health care has been found to be more dangerous for violence-related injuries, as well as musculoskeletal injuries and exposures. One union found that health care workers in Ontario in 2016 missed 25,300 days of work – or more than 69 years – because of workplace violence and harassment.[7] The number of violence-related lost-time claims for frontline health care workers has increased by almost 66% over the past decade, three times the rate of increase for police and correctional service officers combined.[8]

The International Context

The International Labour Organization Convention is currently studying the issue of workplace violence in the world of work with a view towards standards setting. It concluded that workplace violence represents an abuse of power, and that women are disproportionately affected by workplace violence, including domestic violence in the workplace.[9] Recognizing Canada's role on the world stage as a proponent of gender equality and labour rights, Canada has a role to play in these negotiations by advocating for the highest standards on workplace violence prevention in the ILO Convention on the world of work negotiations. Further, Canada could illustrate its commitment to the issue by being one of the first countries to ratify the agreement, and by vigorously committing to implement the convention through all the levers available to the federal government. Occupational health and safety legislation must be built on a strong legal framework that includes a recognition of the essential role of labour in joint occupational health and safety committees, a gendered analysis, and initiatives to recognize and prevent domestic violence at work. The federal government, along with the provinces and territories, should build awareness and understanding of the costs and consequences of violence against women and men in the world of work though campaigns, policy development, stakeholder engagement, alongside the identification and collection of national workplace violence indicators.

The Federal Government as a Leading Employer

Although all provinces in Canada have legislation to address workplace violence, legislation across Canada remans highly uneven. At the employer level, some hospital and health centre policies are models of innovation, while others lack even the basic elements for violence prevention.

As an employer, the federal government has a role to play in modelling best practices that can be disseminated across Canada. The federal government recently passed Bill C-65, *An Act to amend the Canada Labour Code (harassment and violence), the Parliamentary Employment and Staff Relations Act and the Budget Implementation Act*. The federal government must commit to workplace violence legislation/regulations that are leading practices in Canada.

Relatedly, the federal government has also committed to developing and implementing a comprehensive strategy to address mental health within the federal public service – to help build on the

National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard)[10] – by including training for staff in identifying hazards, evaluating, and building on existing programs and policies, as well as developing recommendations for next steps. A Centre of Expertise on Mental Health in the Workplace has also been established. Both these initiatives involve the active participation of labour as leaders in joint health and safety committees (JHSC).

Where applicable, best practices at the federal level offer promising models to target deficiencies in provincial legislation and provincial capacity to address workplace violence and related psychological health and safety issues.

Recommendation: That the federal government apply best practices around violence prevention in federally regulated health care settings, in order to lead by example.

Policing and Security Training

Police and security have an essential role to play in violence prevention programs in health care. Engaging with police officers in the creation of violence prevention programs, encouraging police officers to support health care facilities in violence prevention, and developing protocols to ensure that, when violence does occur and incidents are reported to police, a proper investigation is conducted and charges are laid (if warranted) are some of the measures that need to be taken to integrate police into violence prevention and response programs. The federal government has a role to play in facilitating the integration of police officers in supporting workplace violence prevention and response measures, especially with respect to the national RCMP.

Many security guards in health care facilities lack the appropriate training to safeguard the security of patients and health care providers. Much of the existing training for security focuses on securing property rather than people, and health care security requires the highest level of training in order to prevent workplace violence from occurring. Nurses should not be expected to intervene with violent family members or patients. Security should be in-house and readily accessible when incidents occur; regular in-person training in hands-on de-escalation techniques and other measures should be provided. In order to meet the needs of health care environments, the *minimum training* for health care security should be the Canadian General Standards Board (CGSB)'s standard for security officers and security officer supervisors. Crisis management, effective communications training, hospital specific training, as well as *Mental Health Act* training, should also be part of any minimum standard, as required by the patient population.[11] [12]

While the inclusion of minimum security roles and training requirements and greater availability of in-house security might create up-front costs, the downstream benefits are myriad. Where these measures have been implemented, within a comprehensive violence prevention program, there have been reduced injury rates for clinical staff, patients and visitors, overall enhanced wellness amongst staff and, perhaps most importantly, fewer lost-time incidents. The success of security measures to prevent violence can also be seen in dramatic declines in use of force as was evident at Michael Garron Hospital in Toronto.[13] The use of highly trained peace officers by Alberta Health Services also represents a leading provincial practice.[14]

Of course, appropriately trained and supportive security staff must be implemented as part of any larger violence prevention program, developed in partnership with unions, including frontline training,

reporting, preventive risk assessments, improved communication technologies, flagging of violent patients (included in the patient file) and families, alongside better identification and care plans for patients with a history of violent behaviours.[15]

Recommendation: National minimum security training standards for health care environments need to be legislated, and protocols for responding to, and investigating, workplace violence incidents, when they do occur, need to be established.

National Legislation: Legal Action to Be Taken

Since 2004, Canadian employers and individuals in both the public and private sector can be charged with criminal negligence for failing to ensure their personnel have the information, training or equipment required to do their jobs in a safe manner. The Westray Bill as it is called – in reference to the coal mining disaster that killed 26 workers – has not been used often and has never been deployed against any health care employer. However, as we continue to see nurses' careers cut short by avoidable violence, we believe the Ministry of Justice needs to better train prosecutors around the tenets of Westray and encourage them to consider charging health care employers under Westray in cases where nurses suffer avoidable assault. There have been cases where provincial ministries of labour have brought orders against hospitals, hospitals have been fined, and in some cases charges have been laid. Sometimes these measures are effective at bringing about change, but often they are not. Criminal prosecution of a health care employer could set a precedent to spur changes across Canada and encourage institutions to invest in health care violence prevention programs.

Recently, MP Don Davies introduced Bill C-434, which amends the *Criminal Code* to require a court to consider the fact that the victim of an assault is a health care sector worker to be an aggravating circumstance for the purposes of sentencing. Introducing this bill is in line with similar legislation that already exists for police officers and transit drivers, who also have a regular exposure within their workplaces to the potential for violent attacks from the public. Of course, consideration would be made for those who fall under the category of Not Criminally Responsible, such as dementia patients and those with mental illness or in states of psychosis. This legislation is intended to act as a deterrent against violence; it will help to raise awareness about the issue amongst police and the public. As with all cases of assault, workplace violence should be investigated by police, not left in the hands of the hospital administration or, as is so often the case, of the victims themselves to deal with.

Recommendation: That HESA offer its support for Bill C-434, as well as promote the use of the Westray Bill amongst Crown prosecutors in cases involving health care workers.

Targeted Funding – National Data Collection

Management expert Peter Drucker stated: "You can't manage what you can't measure." Currently, standardized national statistics on workplace violence in health care do not exist. Different provinces collect and report different data, based on different criteria. The Canadian Institute for Health Information (CIHI), which collects and reports on facility-level data, needs to publicly report on facility-level workplace violence-related data. Some potential provincial performance indicators that should be collected (and publicly disseminated) are: a) rates of workplace violence overall and stratified by consequence of violence; b) percent of hospitals with an organizational strategic priority focused on workplace violence; and c) rates of workplace violence, stratified by whether (i) a flagged patient was

involved, (ii) force was used, (iii) a root cause analysis was undertaken, and (iv) a Code White was called.[16]

Recommendation: Federal funding needs to be targeted towards CIHI's collecting and reporting on health care facility-level workplace violence-related data.

Targeted Funding - Violence Prevention, Protection and Post-Incident Response

Comprehensive violence prevention programs need to be allocated targeted funding. In order to protect workers, occupational health and safety must focus on the 3Ps: *Prevention, Protection, and Post-incident Response***.** In the early 2000s, the federal government provided $3 billion in targeted funding to provinces and territories. Now, the infrastructure that is required for violence-prevention programs includes devices/personal alarms (linked to security with GPS and two-way voice communication), advanced and regular ongoing security training focused on de-escalation, occupational health and safety training for staff, comprehensive risk assessments (environment and individual) and flagging of patients with a history of violence.[17]

Recommendation: Targeted federal funding is needed to enhance protections for health care workers through violence-prevention infrastructure and programs, with labour included as an essential partner.

Inadequate Staffing – the Root Problem

While violence prevention programs are vital, the dramatic increase in violent incidents over the past decade point to a larger problem of inadequate staffing. Given media reports of nurse shortages across the country, which are often related to increased incidents of violence, the CFNU is raising the alarm that Canada is on the cusp of a crisis in care. A comprehensive study in health human resources planning is needed to determine current and future shortages, and equip governments across Canada with the tools to address these shortages. In 2009, CNA published *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*, which found that unless concerted action was taken, the shortage of registered nurses who provide direct care to Canadians would rise to 60,000 FTEs in 2022. Since then, there has been no national focus on pan-Canadian health human resources planning.[18]

The CFNU reported that nurses worked more overtime in 2016: public sector health care nurses worked an estimated 20.1 million hours annually of both paid and unpaid overtime (up from 2014) at an estimated cost of $968 million annually. This number is equivalent to 11,100 full-time positions, suggesting that overtime is being used as a regular part of scheduling in health care facilities.[19]

From 2016-2017, the annual growth of the regulated nursing workforce (RNs, LPNs, RPNs) was the slowest in a decade: just 0.7%. The slowdown has been attributed to the following factors: a) declining numbers of new nursing graduates, b) retirement, as growing numbers leave the profession late in their careers, and c) an increase in part-time and casual positions. Notably, the growth in the number of RNs employed in the workforce over the past decade (a group that represents the majority of the nursing workforce) has been the slowest of all the regulated nursing categories.[20] An international study based on OECD data found that compared to 10 other high-income countries, Canada was in the bottom three in terms of nurses per 1,000 people, and below the average.[21]

Recommendation: A comprehensive federal study into human health resources planning.

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