

ENOUGH IS ENOUGH

PUTTING A STOP TO VIOLENCE IN THE HEALTH CARE SECTOR

- A DISCUSSION PAPER -



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



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About this discussion paper

The Canadian Federation of Nurses Unions has produced this discussion paper in order to catalyze a national discussion on violence in health care – one that brings together the disparate stories from coast to coast, highlighting its broad and pervasive impacts. Further, this paper is intended to serve as a national Call to Action. As the national federation of nurses' unions, representing close to 200,000 frontline care providers, and nursing students, the CFNU is calling on governments, employers, unions and frontline nurses themselves to work together to put a stop to violence in health care.

Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.



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A MESSAGE FROM THE CFNU

Linda Silas, President

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. It is time to speak up, and say clearly and emphatically: "Violence is not part of our job!" This is the take-home message of CFNU's discussion paper, *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*.

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. CFNU's recent poll on patient safety and working conditions for nurses found that 61% of nurses have had a "serious" problem with some form of violence in the past 12 months, whether bullying, emotional or verbal abuse, racial or sexual harassment, or physical assault, but unfortunately, only about a quarter of these nurses sought help from their nurses unions (and only 60% reported it). Significantly, two thirds (66%) of nurses have thought of leaving their job in the past year, either to work for a different employer or go into another occupation.

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. Violence is a symptom of an unhealthy work environment. It contributes to nurse absenteeism (own illness or disability): 9.0% for full-time public sector health care nurses in 2016, compared to 5.7% (average of all other occupations). In 2016, the annual cost of absenteeism due to own illness or disability is conservatively estimated at \$989 million.

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, bullying, harassment and abuse – whatever the form and whatever the source. This paper is a Call to Action – one that encourages all nurses to tackle the issue of violence. Collectively, speaking with one loud voice, we can put a stop to violence.

The CFNU is calling on governments, employers, unions and other health care stakeholders to come together because we all have an interest in tackling this problem. This paper offers a way forward to take action on violence with the following recommendations.



CFNU Recommendations

Identify and advocate for provincial policy and legislative levers

That the CFNU and its member organizations work with provincial/territorial governments:

- *To strengthen and improve OH&S legislations so as to create safe workplace standards for health care workplaces.*
- *To ensure meaningful and consistent enforcement and reporting, as well as strong language around the prevention of violence and bullying in health care workplaces, through risk assessments, education, training and emergency preparedness.*

Identify and advocate for federal policy and legislative levers

That the CFNU and its member organizations work with the federal government:

- *To ensure charges are laid, when appropriate, under Bill C-45, otherwise known as the "Westray Bill" (Section 217.1 of the Criminal Code), against organizations and individuals if they fail to ensure the safety of workers and the public.*
- *To amend the federal Criminal Code (Section 269.01) to require a court to consider the fact that the victim of an assault is a health care worker to be an aggravating circumstance for the purposes of sentencing.*
- *To include health care workers and physicians in the federal PTSD framework across Canada.*

"It's a pressure cooker out there for nurses on the front line."

Identify and develop potential enablers/alliances

That CFNU and its member organizations:

- Develop memorandums of agreement with the Crown and police to improve the investigation of workplace safety incidents and make it easier to lay criminal charges against patients who assault nurses.
- Host a meeting with federal/provincial/territorial health ministers on a Violence Is Not Part of the Job campaign.

Act as the lead on violence prevention, developing national resources and data

That CFNU and its member organizations:

- Host a national roundtable on violence in health care.
- Develop and disseminate a communications strategy to bring national attention to the issue of violence against nurses.
- Highlight best practices in the health care sectors with a national violence prevention toolkit.
- Undertake a national survey to obtain data on workplace violence from all provinces.

As nurses, we are committed to caring for our patients, to helping them get well. 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 PTSD symptoms, all of which erode our ability as nurses to provide quality care and safeguard the health and wellbeing of our patients. As Justice Archie Campbell, who led the SARS Commission in Ontario, reminded us, if workers aren't safe, neither are patients. If the mining industry can enforce strict OH&S standards, to safeguard workers safety, then we as nurses also deserve workplaces with zero tolerance of violence.

Change won't be easy. We are working in workplaces where violence has been normalized. Where even other nurses may tell us to 'suck it up'.

"As nurses, we reject violence as 'just part of the job' and we will be part of the solution!"

- CFNU President Linda Silas

We need a drastic change in the culture of our health care workplace – from one that responds to violence after it occurs to one that prevents violence before it occurs. For change to happen, it will involve all of us working together – governments, employers, unions and yes, nurses themselves. As nurses on the front line, coping with violence, the change starts with us every day when we go to work.

What does positive cultural change look like?

One provincial example in Ontario described in the paper is the Michael Garron Hospital (formerly Toronto East General Hospital) which established a violence prevention program, developed in partnership with the Ontario Nurses' Association. Among its key features were comprehensive frontline training, reporting, preventive risk assessments, improved communication technologies, better identification and care plans for patients with a history of violent behaviours, and an appropriately trained and supportive security staff. The result has been a proactive responsive workplace culture. It may not be perfect – no doubt that more needs to happen – but this example provides a roadmap for change. It shows what can be accomplished when employers and unions work in partnership towards systemic change with the goal of preventing violence in health care settings.

I would like to thank Carol Reichert, the author of *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*, CFNU's project team, and the members of CFNU's OH&S network: Dewey Funk (UNA), Denise Dick (SUN), Tom Henderson (MNU), Erna Bujna (ONA), Jennifer Dickison (NBNU) and Paul Curry (NSNU), for their work on this report which serves as a Call to Action for the CFNU, its member organizations and nurses across Canada.

As nurses, we reject violence as 'just part of the job' and we will be part of the solution!

In solidarity always,



Linda Silas
CFNU President

1. EXECUTIVE SUMMARY

Violence in the health care sector is on the rise; violence – whether verbal, or physical, or both – happens every day in our health care facilities from coast to coast. The cost of violence in Ontario hospitals alone is about \$23.8 million annually, making up 10% of hospital lost-time injuries,¹ the majority of these injuries occurred among nurses.² Understaffing and inappropriate staffing, a lack of security, the increasing patient population, as well as the rise in patients' acuity and complexity, are all contributing to an erosion of safety for both patients and staff. The situation in hospitals is particularly acute in emergency departments and in psychiatric facilities. Emergency departments are at the front lines of health care. Since anyone can wander in off the street, the risks are unknown and difficult to assess. Patients in emergency departments are under stress and frequently in pain, facing long wait times in overcrowded rooms. Armed police may bring in individuals who have been involved in altercations, are high on drugs, or have mental health issues, and then leave them with staff in emergency. Psychiatric facilities or departments, where patients are suffering from mental health disorders, are another setting where there is a high potential for violence. Finally, in long-term care, where staffing has not kept pace with the numbers – often one or two nurses provide care for upwards of 100 individuals – nor with the rising acuity levels of residents, violence is a common, everyday occurrence.

Violence, bullying and domestic violence impacts in the workplace affect all nurses and their work environments. They contribute to high numbers of lost-time injuries. The Association of Workers Compensation Boards of Canada (AWCBC) 2015 accepted lost-time injury statistics show that the health care/social services industry tops the list for the number of lost-time injuries at 41,111, representing about 18% of all lost-time injuries. This dubious distinction is one the health care/social services industry has held for a number of years.³ In 2015, frontline health care workers had more than double the number of violence-related lost-time injuries when compared to police and correctional services officers combined. More significantly, while the number of lost-time injuries

for police and correctional service officers, taken together, has risen gradually over the past decade, the number of lost-time injuries for frontline health care workers has grown at three times the rate for police and correctional service officers, rising year over year (see Figure 1).⁴ Lost-time injuries contribute to the high rates of nurse absenteeism in Canada. The rate of absenteeism for full-time public sector health care nurses in 2016 was 9.0%, substantially higher than the average for all other professions (5.7%), leading to annual costs estimated at \$989 million.⁵

Awareness of the problem of violence in health care settings is growing in Canada, but legislation, policies, practices and enforcement have lagged behind. Violence is an occupational health and safety hazard – all provinces recognize this in their Occupational Health & Safety (OH&S) legislation, except for the province of New Brunswick. It is the CFNU's position that employers should strive to mitigate and, ultimately, aim to eliminate all forms of violence. Nurses have the right to work in an environment that is free from all forms and sources of violence, bullying, harassment and verbal abuse whatever the source (i.e., patients, families, doctors, colleagues, management) or origin (internal or external to the facility). Violence in workplaces impacts both staff and patients. It erodes the quality of care and impacts health outcomes. As the Honourable Justice Archie Campbell, who led Ontario's Commission of Inquiry⁶ into the SARS tragedy, noted, "*if workers are not protected from health and safety hazards, patients and the public are not protected either.*"⁷ Unsafe violent workplaces are unsafe for everyone.

Evidence suggests the situation with respect to violence and bullying has worsened over the past two decades. Unfortunately, because the government agencies that would undertake a comprehensive survey on nurses' health have failed to act for more than a decade, the CFNU must fill the void, piecing together a fragmented picture. From the data that is available a picture is emerging – one where nurses are being assaulted and abused on a regular

basis, creating hazardous workplaces for nurses and potential safety and security risks for patients. While all health care workers are impacted by the increasing violence in health care settings, rates of violence correlate to patient contact time. Therefore, regulated nurses and nursing aides are, by definition, among the most at risk for violence.

We know violence is occurring – we know the workers that are most at risk – and we have positive examples of what works to help reduce violence against health care workers. As such, the failure of governments to take concerted action on the issue is deplorable. In the absence of government’s meaningful and consistent enforcement of provincial OH&S legislation, and related federal legislation, many employers are refusing to acknowledge the extent of the problem, and some are even silencing nurses who speak up.

As nurses, we will not be silenced; we will speak up.

The CFNU and the Canadian Nurses Association *Joint Position Statement on Workplace Violence and Bullying* calls for zero tolerance of violence in health care workplaces. It states, “It is unacceptable to work in, receive care in, govern, manage and fund health-care workplaces where violence and bullying exist.”⁸ For the purpose of this paper, violence is defined as the exercise of physical force by a person against a worker, that is work-related, that causes or could cause physical injury to the worker; violence can also take the form of verbal abuse. Both physical and verbal abuse result in psychological and emotional repercussions for workers. CFNU and CNA’s *Joint Position Statement on Workplace Violence and Bullying* describes bullying as “generalized psychological harassment”; bullying is a form of “psychological aggression and intimidation.”⁹ High rates of bullying in health care represent a human resource challenge for employers seeking to retain finite resources.

In the absence of sufficient and comprehensive data on violence against health care workers in Canada, and in light of fragmented approaches to dealing with the issue, this paper aims to fill the gap by telling the stories of those most impacted – frontline nurses. This paper aims to catalyze a national discussion on violence in health care – one that brings together the disparate stories from coast to coast, highlighting its broad and pervasive impacts. Further, this paper is intended to serve as a national Call to Action. As the national federation of nurses’ unions, representing close to 200,000 frontline care providers and nursing students, the CFNU is calling on governments, employers, unions and frontline nurses themselves to work together to put a stop to violence in health care.

Violence should never be ‘just part of the job’!

2. INTRODUCTION

A Call to Action – Putting a STOP to Violence in Health Care

This paper documents the decline of the health and workplace environments of nurses over the past decades by focusing on the escalating tide of violence as it impacts frontline workers. Given the dearth of data since the last major survey of nurses' health was undertaken in 2005, and nurses' understandable reluctance to speak about their experiences with violence, either because they accept it as part of the job, or because they fear career repercussions, this paper does not propose to provide a comprehensive discussion of the issue. Any picture of violence in the health care workplace is necessarily incomplete. Nurses may feel – and be told by their managers – that if it was not a physical attack, violence does not need to be reported to their employer or workers' compensation boards. Other nurses may even reinforce this narrative, telling nurses to 'suck it up'. In this way, violence in the workplace is normalized. Nurses become inured to violence and reluctant to report it. When they do speak up, nurses may face retaliation: a nurse was fired for reporting violence, according to a recent media report.¹⁰ A consultant with the International Council of Nurses (ICN) estimates that "70% to 80% of assaults are never reported."¹¹ The CFNU and its member organizations are sounding the alarm – it is time to put a STOP to all forms of violence, bullying and harassment in health care.

Over the past decade, violence in the health care sector has increased dramatically (Figure 1) – both the number and intensity of attacks are growing at an alarming rate. The rise in violence-related incidents has paralleled, and may be linked to, other negative trends that impact nurses' work environments and patient care, such as increases in nurses' workloads, inadequate or inappropriate staffing, and excessive use of overtime. Violence is pervasive throughout all health care sectors, impacting all those who work in hospitals, the community and long-term care facilities. In hospital settings, those who work in emergency rooms and psychiatric care have been shown to be particularly at risk. Home

care, where nurses work in isolation, and long-term care facilities, where there are few staff for many residents, many of whom suffer from dementia, and increasing levels of acuity, also have high rates of violence. For example, in Nova Scotia, where the seniors' population is outpacing investments in nursing homes, violence-related injuries to staff are disproportionately high in long-term care when compared to the acute care sector.

In health care, violence is impacted by, among other factors, inappropriate admissions of patients into facilities that are ill-equipped to deal with the patients' acuity/complexity; short staffing and inappropriate staffing, particularly in high-risk areas; inadequate or inappropriate security or security measures; inadequate communications protocols/practices with respect to violence risks; lack of violence-prevention training; isolated work assignments (night shifts, home and community care, long-term care); poorly managed transportation/ placement of patients (e.g., lack of secure rooms in emergency) and unrestricted access to health care facilities.

Violence and bullying can take many different forms: overt – physical, verbal, psychological (e.g., intimidation, threats of harm), and sexual behaviours; or covert – neglect, rudeness, humiliation and withholding information. Violence and bullying can occur between employees – colleagues at different levels in the organization (i.e., horizontal, vertical), or the source can be from those external to it – non-employees (e.g., patients, families, visitors).

Domestic violence is also emerging as a workplace issue in health care settings and is garnering the attention of governments, employers and unions. Canadian and international research has found that domestic violence often spills over into the workplace, compromising workers and their colleagues' personal safety and security.¹²



3. BACKGROUND

The last national comprehensive government survey to consider the health and wellbeing of nurses was conducted by Health Canada, Statistics Canada and the Canadian Institute for Health Information (CIHI). Entitled *Findings from the 2005 National Survey of the Work and Health of Nurses*, it found that of the nearly 19,000 regulated nurses surveyed, about a third of hospital nurses had suffered physical abuse at the hands of patients over the previous 12 months. In long-term care homes, the situation was even worse with about 50% of nurses reporting physical abuse by patients in a 12-month period.¹³

The 2005 survey also took into account emotional or psychological abuse. Emotional abuse from patients, visitors, physicians and other nurses was experienced by nurses. Close to 50% of nurses working in both hospitals and long-term care were emotionally abused by patients. The findings on violence and emotional abuse from the 2005 survey of nurses may be linked to the higher rates of reported depression in nurses (almost one in 10) and to the higher rates of medication use, when compared to the general employed population. For example, 8.5% of nurses had used sleeping pills in the previous month, perhaps as a result of sleep disturbances from irregular shift work, exceeding the usage for even other shift workers. The vast majority of nurses also took aspirin- or acetaminophen-based pain relievers or anti-inflammatories during the month – a higher usage than the general employed population.¹⁴

Please refer to survey results on the following page

It is notable that the term ‘bullying’ is not used in the 2005 survey questions. However, the survey does refer to ‘emotional abuse’ and ‘being exposed to hostility and conflict from the people you work with’. Awareness of “bullying” as a significant factor impacting workers’ health, wellbeing, productivity and retention has grown over the past decade. While bullying data is self-reported and not readily collected, all evidence points to high rates of bullying in the health care profession, both from external sources (non-employees) and internal sources (employees). This is particularly true for young nurses, who may leave the profession due to the reality shock of encountering both high workloads and bullying from colleagues, other members of the health care team, managers, and patients and their families.¹⁵

Similarly, the mental health of frontline health care workers including nurses – as expressed through high rates of burnout, compassion fatigue, depression and PTSD – has been steadily eroded over the past decade, following a similar trajectory to that of firefighters, police and correctional service officers (Figure 2).¹⁶

In addition to violence and bullying, this report will explore domestic violence as a workplace issue. Australia’s joint efforts by governments, employers and unions to recognize domestic violence as a workplace issue have galvanized Canadian unions, in conjunction with academic researchers, to take action on this issue.

2005 National Survey of the Work and Health of Nurses¹⁷

	Physically assaulted by a patient over 12-month period	Emotionally abused by a patient over 12-month period	Experienced depression in 12-month period	Physical/mental health made it difficult to handle workload over past 4 weeks	
				Physical	Mental
National	28.8	43.6	9.4	31.2	18.4
NL	36.2	43.5	5.3	34.1	12.6
PE	27.4	43.8	5.7	27.4	14.5
NS	32.2	43.3	9.0	30.0	16.0
NB	30.4	41.7	8.6	32.0	17.5
QC	26.5	35.3	10.7	28.5	15.4
ON	28.4	44.9	9.0	32.1	18.9
MB	32.9	49.1	9.1	34.5	23.1
SK	32.2	51.6	8.4	36.7	22.3
AB	25.3	47.2	10.3	28.5	19.2
BC	32.5	50.0	8.7	33.5	22.1
YT, NT, NU	27.1	58.6	7.1	18.8	16.8

4. FINDINGS

A) Violence in Health Care: A Worldwide Epidemic

Violence against health care personnel is a widespread problem throughout the industrialised world, as well as in developing and transitional countries, and it affects health care workers in nearly all work environments – assault can take the form of intimidation, harassment, stalking, beatings, stabbing, and rape. Perpetrators tend to be primarily patients, their families and visitors.¹⁸ A 2013 global review that estimated nurses' violence exposure rates, drawing on data from more than 150,000 nurses from 160 international samples, found that more than a third of nurses had been physically assaulted, and around two thirds had experienced non-physical assaults. Physical violence was most prevalent in emergency departments, geriatric and psychiatric units. Both physical violence and sexual harassment were most prevalent in the Anglo region, which included the U.S., Canada and England. Forty per cent of nurses experienced bullying.¹⁹ The World Health Organization recognizes that health workers are at high risk of violence all over the world. It notes that not only is violence unacceptable, but that violence has a cascading effect, impacting the psychological and physical wellbeing of health care staff, their job motivation, compromising the quality of care, and leading to health care sector financial losses.²⁰

U.S.

Health workers experience assaults at significantly higher rates than that of other occupations: eight assaults per 10,000 workers compared to two per 10,000 for the general workplace.²¹ Thirty-five percent of attacks occur in hospitals; 53% in nursing or residential care facilities.²² In the U.S., attacks on health care workers account for about 70% of all non-fatal workplace assaults that lead to days off from work.²³

England

In total 70,555 National Health Service staff in England were assaulted in 2015-2016, according to NHS Protect figures. This was an increase of 4% over the previous year.²⁴ A petition calling for it to be a specific offence to attack any member of the NHS staff states that there are 193 attacks on NHS staff every day in England, which means there are eight attacks on workers in health care settings every hour of every day.²⁵

Europe

Results from the European project NEXT involving 10 EU countries, focused on premature departures from the nursing profession, found that exposure to frequent violent events was highest amongst nurses from France (39%), the United Kingdom (29%) and Germany (28%). In France, 19.5% of nurses experienced violence at least once a week from patients or their relatives; in the UK the figure was 12.3%, and in Germany it was 11.5%.²⁶

B) Violence in Health Care in Canada: A Complex Narrative

As indicated, Canada has not undertaken a major national survey of nurses' health and their workplaces since 2005. Building a profile of what is happening in Canada with respect to violence and the health of nurses means cobbling together data from various sources. The data from various provincial nurses unions shows that nurses are getting hurt on a daily basis. Physical and verbal abuse are experienced by most nurses; during the course of their careers almost all nurses will experience violence. Together, the data paints a picture of a dangerous workplace – one that is unsafe for both nurses and patients. Being punched, kicked, spat on, slapped, pinched and verbally abused are common occurrences in all health care sectors, in all provinces and territories. Below you will find a small snapshot of what is happening in Canadian hospitals, which reflects the broader picture of the enormous toll that everyday violence takes on our health care workers, our patients, and our health care system as a whole. This is unacceptable and must be addressed by a concerted effort on the part of governments, employers and unions working collectively to end violence.

Violence in Hospitals

In Nova Scotia's emergency rooms, from January to November 2016, there were 61 incidents of violence and threats. In October 2016, an armed man threatened emergency department staff at Middleton's Soldiers Memorial Hospital, prompting a joint union and government response to violence and a comprehensive action plan.²⁷ In New Brunswick, emergency rooms are described as places where nurses are routinely spat upon and sworn at during the course of their work.²⁸ In 2015, in the violence-plagued Abbotsford Regional Hospital emergency room in B.C., three quarters of ER staff said they had been physically assaulted while working in the previous year, with more than half saying they had experienced such abuse more than 20 times over a 12-month period.²⁹

In Saskatchewan, almost three quarters of registered psychiatric nurses reported experiencing violence (physical and/or verbal)³⁰ during a 12-month period. One study has shown the rate of workplace violence in psychiatric settings as being three times the already high rate for nurses.³¹ In Ontario, there have been a rash of charges brought against psychiatric facilities due to extremely violent incidents that have occurred. In March 2017, the Ministry of Labour, in the latest series of charges, laid three charges against Waypoint Centre for Mental Health Care under the *Occupational Health and Safety Act (OH&S Act)*. The charges related to an incident at the hospital in April 2016, involving a patient stabbing a nurse with a screwdriver.³² However, these charges came after a disappointing decision, when a Brockville judge acquitted the Royal Ottawa Mental Health Centre of four of five provincial charges laid, after a mentally ill patient stabbed a nurse multiple times in the head and neck in 2014, leaving her seriously injured.³³



A Snapshot of Violence in the Canadian Health Care Sector

- **Alberta and British Columbia:** Of 8,780 RNs in Alberta and BC in 210 hospitals, 46% had experienced violence in the previous five shifts.³⁴
- **Saskatchewan:** Almost 75% of Saskatchewan Registered Psychiatric Nurses (RPNs) had experienced violence in the previous year; 33% physical violence; 64% reporting verbal abuse.³⁵ In one health region, Regina Qu'Appelle Health Region, violent incidents almost doubled from 224 to 416 over the past year.³⁶
- **Manitoba:** 52% of Manitoba's nurses have been physically assaulted, 17% have dealt with an individual with a weapon, and another 76% have been verbally abused; 37% of nurses working in psychiatric units, and 30% of ER nurses experience physical violence *at least once per week*.³⁷
- **Ontario:** 54% of Ontario nurses have experienced physical abuse; 85% experienced verbal abuse, and 19% have experienced sexual violence or abuse.³⁸
- **Quebec:** 86.5% of nurses have been the victims of violence on more than one occasion.³⁹
- **New Brunswick:** 66% of nurses had experienced physical or verbal abuse during a one-year period.⁴⁰
- **Newfoundland and Labrador:** 87% of nurses had experienced some form of violence or abuse in the workplace. Physical abuse was reported by 52% of nurses working in acute care.⁴¹

Please note: The above data was collected during different time periods, with different survey parameters, making cross-provincial comparisons difficult; this furthers the case for an update of the national survey with fully comparable data.

Violence in the Long-Term Care Sector

In 2015, the CFNU raised the alarm with respect to seniors' care in its report, *Before It's Too Late: A National Plan for Safe Seniors' Care*, which called for a national strategy with minimum standards of care.⁴² Since that report, the long-term care sector, which was already struggling to meet seniors' health needs, has become increasingly dangerous for both residents and staff.

Ontario, where the majority of long-term care facilities are for-profit, also suffers from some of the lowest staffing levels.⁴³ In Nova Scotia and New Brunswick, where long-term care facilities are at capacity due to the high seniors' populations in these provinces, staffing remains inadequate.^{44,45} Staffing has not kept pace with the number of residents, nor the rising levels of acuity, meaning there is often only one or two nurses caring for 60-100 residents, resulting in threats to everyone's safety. Recently, an access to information request revealed that eight Nova Scotia long-term care residents had died due to violence from other residents over an eight-year period.⁴⁶ In Ontario, there were 12 homicides in nursing homes within a period of two years.⁴⁷ These deaths are not anomalies. CTV's *W5* program found at least 60 nursing home homicides over a 12-year period. While homicides are sensational and reported in the media, *W5* found more than 10,000 "incidents," during the course of one year, of resident-on-resident abuse in long-term care homes.⁴⁸ In Ontario, research by the Ontario Association of Non-Profit Homes and Services for Seniors found that 11% of Ontario's long-term care residents are deemed aggressive.⁴⁹ It is estimated that 60% of those in care have various forms of dementia, and up to 80% of those individuals will at some point exhibit anxiety, depression, paranoia or aggression.⁵⁰

With few provinces having legislated minimum number of direct care hours for long-term care residents, minimum standards of care, or adequate investments in specialized training in gerontology,⁵¹ the situation with respect to violence in these homes is reaching crisis levels in some settings. With a growing seniors' population, increasing levels of acuity and complexity, including a large number of seniors with dementia, the situation in long-term care is poised to become even more precarious over the next decade. A violent workplace is not only unsafe for patients and staff, it also erodes patient care by reducing already low staffing levels through high turnover rates, lost-time injuries, fatigue and burnout.⁵² Physical violence in long-term care is a common experience for almost all frontline health care providers, leading to high rates of injuries requiring time off work. For example, in Manitoba, staff working in long-term care were injured more than 700 times over a five-year period, costing the workers compensation program about \$500,000 per year.⁵³ Similarly, a recent NSNU report in Nova Scotia also found a disproportionate number of violence-related lost-time injuries among staff in long-term care: the hospital, with at least three times the number of employees, had 81 violence-related claims in 2013, compared to 115 in Nova Scotia's nursing homes.⁵⁴

Home care also presents risks for health care workers. In Newfoundland and Labrador, for example, where many community health workers visit people in their rural homes to provide health care, health care workers reported feeling unsafe when conducting home visits. Many experienced verbal abuse but did not report it.⁵⁵ The potential devastating risks were graphically illustrated by the murder of a Camrose mental health worker in a client's home in 2011 in Alberta,⁵⁶ and again in 2012 when a youth worker was murdered at a Camrose group home for teens;⁵⁷ both workers were not sufficiently made aware of the risks of caring for these patients.

A Snapshot of Violence in Long-Term Care (LTC)

- **Newfoundland and Labrador:** 66% of LTC nurses had experienced physical abuse.⁵⁸
- **New Brunswick:** 65% of LTC nurses had experienced physical abuse, and 78% had experienced verbal abuse during a one-year period.⁵⁹
- **Nova Scotia:** 14% of LTC nurses reported incidents of violence frequently (twice a month), 24% often (twice a year); 23% experienced bullying and aggression frequently.⁶⁰
- **Manitoba:** 31% of LTC nurses experience physical violence at least once per week.⁶¹
- **Manitoba, Ontario, Nova Scotia:** In 71 unionized LTC facilities, 43% of personal support workers experienced physical violence on a daily basis, nearly seven times the rate in Denmark, Finland, Norway and Sweden; another 25% experienced violence every week.⁶²

The above data was collected during different time periods, with different survey parameters, making cross-provincial comparisons difficult; this furthers the case for an update of the national survey with fully comparable data.

C) Bullying in Health Care Settings

Even as there has been an increasing focus on mental health in Canada, and on addressing the related stigma, the mental health of health care workers has continued to decline. One of the reasons is the high rates of bullying in health care from colleagues and managers.⁶³ Bullying in health care workplaces is on the rise, but it remains under the radar, with few workplaces acknowledging the extent of the problem.

Bullying may be described as “generalized psychological harassment.” It is a form of psychological aggression and intimidation. Bullying can be amongst colleagues (horizontal) or between staff at different levels of an organization (vertical: e.g., physician-nurse, manager-nurse).⁶⁴ Although awareness of bullying in the workplace has increased significantly over the past decade, there is still no uniform definition of bullying. Further, victims may be reluctant to report bullying (or identify themselves as victims), and hospital administrators may often not recognize the true extent and impact of bullying within the workplace. Without a standard definition and understanding of what constitutes bullying, data collection is difficult. However, common definitions include repeated, frequent, and long-term negative or aggressive behaviours that undermine confidence and lower self-esteem, which the victim feels powerless to defend themselves against or stop. The effects of bullying may be social, psychological or psychosomatic problems. Bullying may take the form of verbal (or physical) abuse, social exclusion, or undermining one’s professional status.⁶⁵

In 2010, Dr. Claire Mallette led a study on horizontal violence (bullying) for the University Health Network. Ninety-five percent of the 160 nurse participants had observed horizontal violence; 71% had been targets. Kathleen Bartholomew, a Seattle-based RN and the author of *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other*, says the situation with respect to

bullying is actually worse in Canada than in the U.S., where it is estimated that 60% of newly registered nurses leave their first job within just six months after experiencing some form of lateral violence.⁶⁶ According to Bartholomew, “studies of workplace instability show that it’s worse in Canada than it is in the United States due to the fact that (Canada has) a culture of being much more polite than Americans.”⁶⁷ In Britain, while official tallies put the rate of bullying among National Health Service staff at about 25%, *The Guardian* newspaper’s own survey found much higher rates. Among 1,500 doctors, nurses and other health workers in hospitals, primary care and community settings, 81% had experienced bullying, and for almost half of them it was still ongoing. A third of those bullied signed off sick, and another 40% needed counselling to cope with the bullying.⁶⁸

Nurses unions have identified bullying as a key HHR issue, particularly with respect to the retention of younger nurses entering the workforce. In terms of health outcomes, bullying has also been linked to medication errors and an erosion in the quality of patient care. Bullying is also costly: the estimated international costs of bullying-related outcomes is between \$17 and \$36 billion annually.⁶⁹

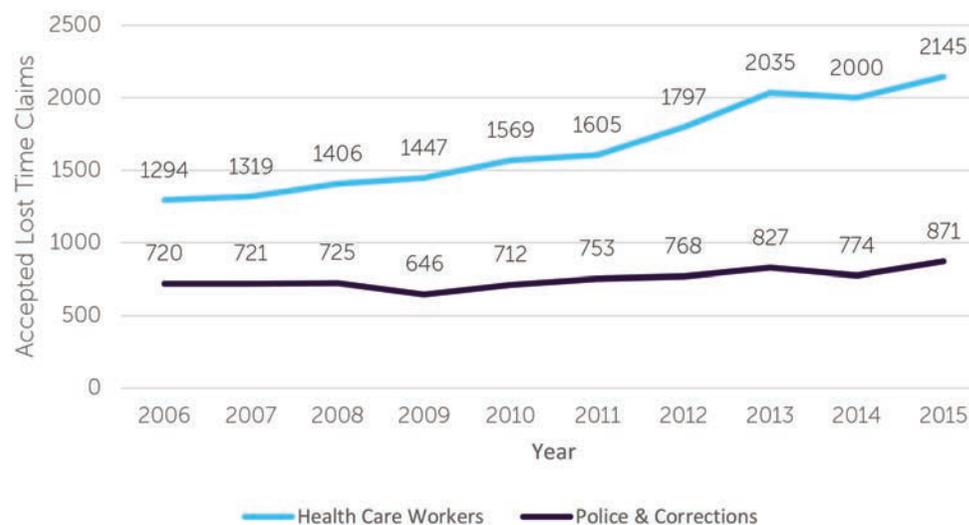
D) The Failure to Act on Violence in Health Care: Rising Costs

The following data vividly documents the extent of the violence against nurses. The problem is growing rapidly, and costs are continuing to rise. Meanwhile, the media continues to focus on the dangers of what is traditionally 'men's work' – 95% of media reports concern men's injuries – even though 37% of injuries involve women. Assaults and violent acts are almost never reported. Media reports continue to focus primarily on fatalities in construction, mining and manufacturing, even though the national data shows that health care and social services are more dangerous in terms of the overall number of lost-time injuries, in some cases – far more dangerous than these traditionally male domains. As the data illustrates, even when compared to police and correctional service officers combined, health care workers experienced more than double the number of incidents that result in violence-related lost-time.⁷⁰ Accepted lost-time violence-related claims for health care workers have increased by almost 66% over the past decade, rising at three times the rate of police and correctional service officers combined. This pattern showing an increase in violence-related lost-time incidents between 2006 and 2015 is evident in every province; in some provinces, violence-related claims have doubled or even tripled. Even taking into account that there are likely more frontline health care workers employed in Canada than police and correctional service officers combined, in 2006, violence-related claims for health care workers were already 80% higher than those for police and correctional officers. In 2015, the gap widened to almost 150%.

Figure 1

Violence-Related Accepted Lost-Time Claims 2006-2015

Health Care (# of claims = 16,617)
Police and Correctional Service Officers (# of claims = 7,517)



Accepted lost-time claims for event or exposure to assaults, violent acts, attacks, harassment, for patient service associates, orderlies, nurses aides, LPNs, RNs, and nurse supervisors in health care and social services in comparison to police officers and correctional service officers - 2006-2015.⁷¹



E) Nurses' Stories: The Experience of Violence on the Front Lines of Health Care

British Columbia



At Abbotsford Regional Hospital Emergency Department, BC, a facility with a history of violence, a registered psychiatric nurse (RPN) suffered a severe concussion after getting kicked in the head by a patient in the ER; two RPNs and a security guard were also assaulted by another patient. In both cases, the assailants had been patients with mental health issues, brought in by police.⁷²

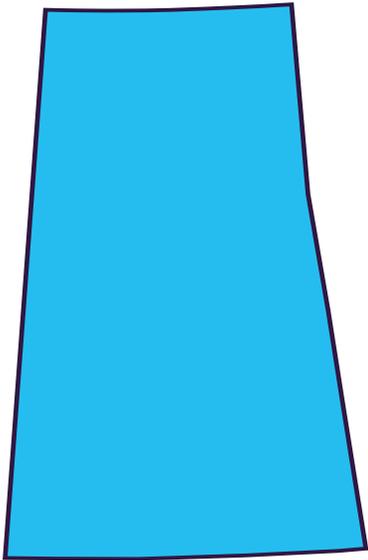
Alberta



A nurse, providing care for an intoxicated patient, was told, "you are going to be my wife." The nurse said this was inappropriate, and asked him not to speak to her like that. When she tried to start an IV, the patient grabbed the nurse's vagina and said, "I'm going to ram my penis down your throat." The nurse restrained his hands, calling security; then the RCMP was called.

The patient was charged, receiving 30 days for assault — not sexual assault. During the same shift, the same nurse was assaulted again, receiving a kick in the back of the head from a child receiving psychiatric care.

Saskatchewan



In 2014, a nurse leaving her late night shift at a hospital in Regina was walking to her parked car when she was attacked by a man who punched her in the throat, the arm and chest.⁷³

Manitoba



At 6:45 a.m. an operating room (OR) nurse was starting her shift. She knocked on the locked OR door. An irate man emerged carrying a large bag and yelling obscenities at her, and fled. The nurse found that the hand sanitizer dispensers were broken; the alcohol gel pouches were missing. Addicts take them because of their high alcohol content. Hospital staff describe feeling like “security guards or bouncers,” scared to be at work, especially at night, when they are alone.

Ontario

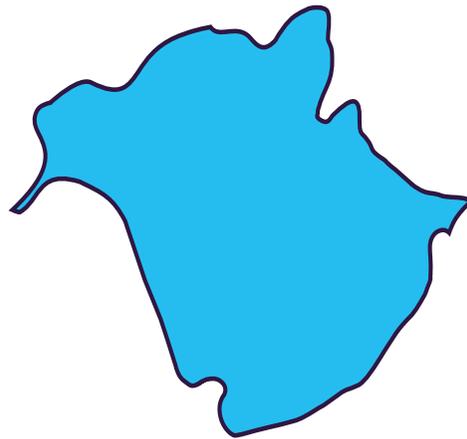
The police had brought in a man to Emergency; he was put in a private room, and they left. Then the man left the room and ran at the nurse. She was punched and kicked in the head and neck many times. Security came and helped her break free. She received a concussion, multiple bruises and contusions all over her body.

A patient grabbed a nurse and locked her and himself in a visitors' room. The patient said he would beat and rape her, then kill her. The patient beat her beyond recognition, while others watched helplessly because no one was able to get in the room. The patient started to rip off the nurse's clothes. The nurse thought she was going to die. A co-worker broke into the room, saving her life. This nurse will never return to work.



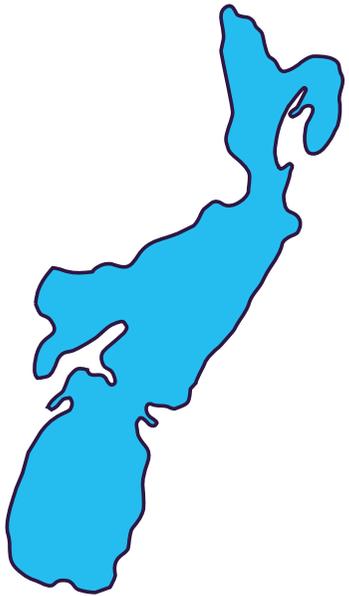
Ontario (Con't)

In one year, in just one hospital in Ontario, where a patient attacked a nurse, choking her, 20 staff were physically harmed – from scratches and bruises to more serious injuries. There were another 200 incidents where staff were threatened.



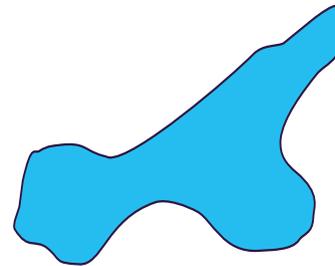
New Brunswick

The police brought in a man to Emergency after he had been in a fight. He was transferred to a unit by staff, who warned that he'd already been violent in the ER. There were several patients in critical condition, one female RN, and a pregnant doctor. The man was assessed by the doctor and lashed out at her; she screamed for help. He then headed towards a patient in traction. The RN stepped in front of the patient and he threw her down, repeatedly beating her head against the floor. By the time the Code White was responded to, the RN had sustained serious head injuries.



Nova Scotia

A nurse in a long-term care home was bending down to tie a resident's shoe when he grabbed her by the hair and slammed her face into the floor – again and again – she lost track of the number of times her face hit the floor. The attack was totally unexpected – the resident had been in a good mood all day. Luckily, somebody overheard her screams and came to help.



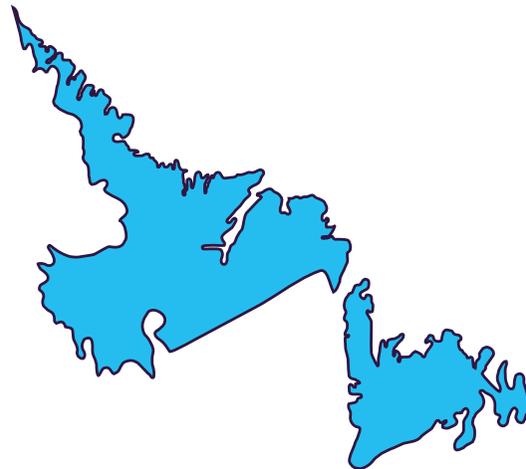
Prince Edward Island

A young nurse was working at a community home in PEI, with 50 residents. Late one evening, a 6'5" male resident suffering from bipolar disorder, violently threw everything electrical from his room out into the hall. The staff (the in-charge nurse and patient care worker) tried to calm him down but he verbally abused them.

The nurse called the doctor and was told to medicate the patient. He refused treatment and continued to berate staff. Called again, the doctor told staff to call police. When the police finally arrived, it took four officers to remove the man from the facility.

Prince Edward Island (Con't)

A resident was wandering on nights. When staff approached, they noticed he was soiled and asked him if he wanted to change his clothes; he agreed. Upon entering his room, the resident turned suddenly and pinned the staff member against the door, putting both hands around their throat. The staff member managed to yell for a colleague, and the resident released his hold.



Newfoundland and Labrador

A patient suffering from paranoid schizophrenia, was admitted to a St. John's Hospital. He punched a doctor and nurse in the face, then pushed another nurse to the floor and punched her several times in the back of the head.

5. MAKING THE LINK

Violence in Health Care Settings and the Mental Health Impacts on Nurses

A number of studies have documented the short- and long-term consequences of repeated exposure to violence. Although treatment for physical violence may eliminate the scars, there may be both short- or long-term psychological consequences in the case of both physical and verbal abuse. Psychological outcomes may include anger and fear, post-traumatic stress disorder (PTSD) symptoms, guilt, shame and avoidance, decreased job satisfaction and increased intent to leave the organization, and lowered health-related quality of life (HRQoL).^{74, 75, 76, 77} Other factors that may be related to violence include sleep disorders, headaches, fear and anxiety.⁷⁸

Violence may be linked to nurses' high rates of burnout and depression. CBC's 2013 *Fifth Estate* program in its national survey of more than 4,500 registered nurses in over 250 hospitals found nearly 40% of nurses suffered from high levels of burnout.⁷⁹ The prevalence of major depression in Canadian nurses is double the national average for working women.⁸⁰

Nurses who are suffering from untreated mental health issues may be prone to addictions. However, because of regulatory practices focused on discipline, and the stigma attached to addictions, nurses may be reluctant and unable to seek help.⁸¹

Violence and Post-Traumatic Stress Disorder (PTSD)

According to groundbreaking research conducted by the Manitoba Nurses Union (MNU), violence, or the threat of violence, plays the largest role in PTSD development in nurses. One in four Manitoba nurses consistently experiences PTSD symptoms; more than half have experienced critical incident stress, a precursor to the development of PTSD.⁸² The frequency of workplace bullying

as a form of violence – a common occurrence in health care workplaces – has also been shown to be significantly related to the development of PTSD symptoms.⁸³ Excessive workloads also play a role: a BC nursing workload study found PTSD symptoms among the nurses studied, with about 35% of nurses requiring further evaluation.⁸⁴ With these factors taken together as a whole, it is not surprising that health care workers have been shown to have high rates of PTSD symptoms.⁸⁵

Post-traumatic stress disorder (PTSD) is a psychiatric disorder – an extreme reaction to either direct or indirect exposure to trauma. Nurses experience trauma on a regular basis in their work environments either directly (primary), as witnesses (secondary), or through vicarious trauma (compassion fatigue). The trauma may be cumulative, resulting in symptoms similar to PTSD (e.g., avoidance) and in disorders such as anxiety and depression. Symptoms of PTSD fall into four categories: re-experiencing, avoidance, negative cognitions and mood, and arousal.⁸⁶ The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) states that PTSD is a psychological reaction following exposure to, or learning of, death or threatened death, serious injury or sexual violence to self or a loved one, or repeated exposure to aversive details of trauma.⁸⁷

Epidemiological surveys have found that PTSD is twice as common in women as in men. In addition, there are gender differences in the type of trauma exposure, presentation of the illness, and the co-morbidities. While some of these differences are non-biological, others relate to how women's biological system altered by PTSD may be modulated by sex hormones.⁸⁸ Since about 90% of the more than 400,000 regulated nurses in Canada are women, PTSD in nurses must be understood in the context of gender differences.

Often nurses may be misdiagnosed with burnout or compassion fatigue. A number of research studies have looked at burnout rates in nurses. At some point in their careers about 71% of nurses will experience burnout, according to research.⁸⁹ The BC workload study found similar rates of burnout, with about 70% of nurses in the study reporting medium to high levels of emotional exhaustion, a key indicator of burnout. Almost 80% of the nurses in this study failed to seek professional help.⁹⁰ A report on the interaction of PTSD and burnout syndrome (BOS) among nurses shows that nurses with PTSD will almost uniformly have symptoms of BOS. Of nurses in this study, 22% had symptoms of PTSD, 18% met the diagnostic criteria for PTSD, and 86% met the criteria for BOS.⁹¹

Given the high rates of PTSD and PTSD symptoms among nurses – and the gendered nature of how symptoms manifest themselves in nurses, such that it is likely nurses are often misdiagnosed with burnout (which is highly prevalent) or other co-morbid disorders – nurses exclusion from presumptive PTSD legislation in Alberta, Ontario, New Brunswick and federally, in Bill C-211, is difficult to comprehend. Nurses who face high rates of violence every day in their jobs should not be doubly victimized when they get sick as a result of this violence by having to relive the trauma of abuse in order to prove to a WCB tribunal that their PTSD claim is justified.



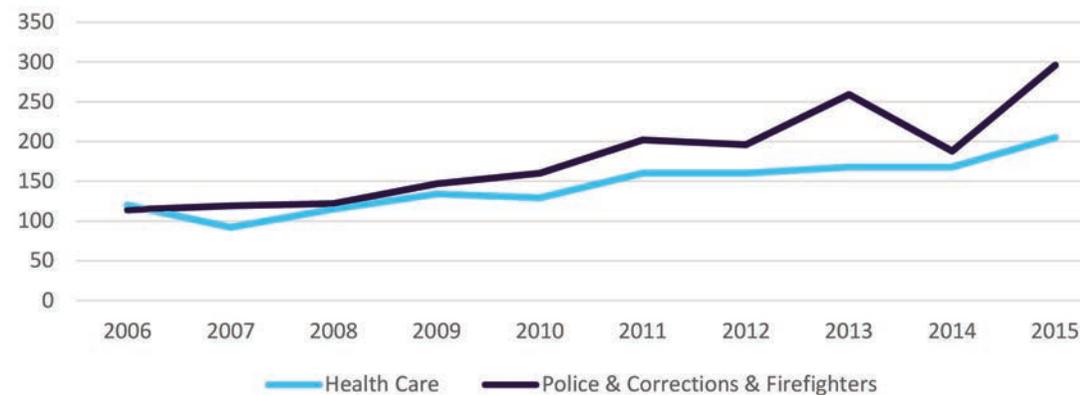


This graph shows the accepted lost-time claims for mental health-related injuries, comparing frontline health care workers with firefighters, police and correctional service officers combined. Although the latter group has a slightly higher number of claims, the two groups are on a similar trajectory in terms of the rates of increase. In terms of accepted lost-time claims for nurses, the percentage of PTSD-related mental health claims were similar, hovering around 50% of total mental health-related lost-time claims for both groups.⁹²

Figure 2

Mental Health-Related Accepted Lost-Time Claims 2006-2015

Health Care (# of claims = 1,451)
Firefighters, Police, Correctional Service Officers (# of claims = 1,803)



Accepted lost-time claims for nature of injury mental health ("52 mental disorders or syndromes") for patient service associates, orderlies, nurses aides, LPNs, RNs, and nurse supervisors in health and social services in comparison to firefighters, police officers and correctional service officers - 2006- 2015.

6. DOMESTIC VIOLENCE AND THE HEALTH CARE SETTING

An Emerging Issue in Canada

In Canada, the Canadian Labour Congress collaborated with Western University in Ontario on groundbreaking research to determine the prevalence of domestic violence impacts in the workplace in Canada. Their survey of workers defined domestic violence as any form of physical, sexual, emotional or psychological abuse, including financial control, stalking and harassment that occurs between opposite- or same-sex intimate partners, who may or may not be married or living together. The survey report entitled *Can Work be Safe, When Home Isn't?* found one third of Canadian workers have experienced domestic violence; in over half of these cases it followed them to work in the form of harassing emails, texts, phone calls or stalking and other intrusive measures. Sadly, 8.5% of victims lost their jobs as a result of domestic violence impacts.⁹³

Internationally, governments, employers and unions have become increasingly attuned to both the personal and financial consequences of domestic violence in the workplace. Thanks to an initiative entitled *Safe at Home, Safe at Work*, led by the Australian government in conjunction with academics, employers and unions, about two million workers in Australia now have domestic violence rights and entitlements as part of their negotiated workplace protections, including leave provisions and safety policies.⁹⁴

The Conference Board of Canada surveyed employers about the impacts of domestic violence in Canadian workplaces. Over 90% of Canadian employers surveyed by the Conference Board of Canada said domestic violence has an impact on workers' performance and productivity; almost three quarters of employers surveyed reported having to protect a victim of domestic violence.⁹⁵ Canadian employers lose \$77.9 million annually due to the direct and indirect impacts of domestic violence (including loss of productivity and late/distracted employees).⁹⁶

Nurses' workplaces are open to the public, with little security. In November 2005, an ONA member, RN Lori Dupont, was murdered by her ex-partner, an anesthesiologist who worked at the same hospital. Lori Dupont had repeatedly expressed her concerns regarding her safety to her hospital employer. The case resulted in the first legislation on domestic violence and the workplace in Canada, with an employer obligation to address domestic violence when it spills over into the workplace.

In New Zealand an analysis of recommended workplace protections that included paid leave provisions, workplace training, and flexible working arrangements found the employers' costs are offset by net improvements in productivity.⁹⁷

Galvanized by international experience, Canadian research, and growing awareness of costs to both employers and employees of not addressing domestic violence, Manitoba passed legislation in 2016, which means workers who are victims of domestic violence are able to retain their attachment to the workplace because they have access to both paid and unpaid leave from work, and guaranteed job security if they have to take time off as they seek safety from abusers. Similar bills are currently being reviewed in Ontario and Saskatchewan.⁹⁸ Due to persistent stigma surrounding domestic violence, workers will only be able to effectively make use of such leave if there are designated people within the workplace, trained to respond compassionately and without judgement, to assist the worker to access the leave in a confidential manner. Therefore, nurses unions, working with the Canadian Labour Congress and Western University, are examining the potential of collective agreement language to address domestic violence in the workplace and to increase proactive policies, training and awareness to reduce the domestic violence workplace impacts.



7. MAKING THE CASE FOR CHANGE

Nurses Unions Take Action

Increasingly, all provincial unions are enhancing their professional responsibility/complaints process in negotiations, through data collection, and through employer-union processes to help prevent the conditions in which violence flourishes.

British Columbia

The British Columbia Nurses' Union (BCNU) has launched a 24/7 hotline for nurses to call if they have suffered an assault at work, with a trauma counsellor available to talk to nurses and a promise of a one-day follow-up from BCNU staff to guide nurses through the process of responding to violent incidents. They have also launched graphic commercials to raise awareness of the issue.

Alberta

United Nurses of Alberta (UNA) is encouraging members to take a stand against violence, following the 2013 successful appeal of disciplinary actions against a group of nurses who had exercised their right to refuse unsafe work. On the night of January 17, 2011, eight RNs and RPNs told their manager they would not treat a violent patient who had previously threatened staff with violence. The patient was being held in a seclusion room the nurses believed to be insecure. When able-bodied security staff had to take physical control of the patient, some were injured; one was placed on modified duties. For failing to treat the patient and place themselves in imminent danger, the nurses were suspended without pay. After considering the evidence on appeal, the employer was ordered to cease all disciplinary action against the nurses, pay them what they would have earned if they had not been disciplined, and remove any reprimand

or other reference to the matter from their employment record. This 'right to refuse' case is precedent-setting, representing a singular victory for nurses in Alberta and across Canada.⁹⁹

Alberta is now also piloting a visual violence alert to identify patients who have exhibited violent behaviours – and is postering facilities throughout the province to raise awareness of violence in the workplace. Those who experience violence are to receive counselling, and UNA has prepared a brochure to help workers negotiate a path to recovery after violent incidents occur.

Saskatchewan

Saskatchewan has announced a Provincial Violence Prevention Framework/Strategy with a toolkit that provides information, training and resources to be rolled out in provincial health care facilities. Saskatchewan Union of Nurses (SUN) sits on the multi-stakeholder Provincial Violence Prevention Steering Committee that meets monthly and is engaged in developing and implementing the strategy to reduce violence and acts of aggression in Saskatchewan's health care sector. Work has started by piloting Ontario's Public Services Health & Safety Association's Workplace Violence Risk Assessment Toolkit (WPRA) in a few selected sites, with the objective of building Saskatchewan's own toolkit.

Manitoba

Informed by the work of the Manitoba Nurses Union on the Minister's Advisory Group, the Manitoba government has established a province-wide violence prevention policy for all health care facilities, which includes mandatory



training for workers, an alert system to identify patients at risk of violence, security measures, and mandatory reporting and investigation of violent incidents. Recently a new symbol has been introduced into Winnipeg health care facilities in an attempt to reduce violence. Two interlocking purple rings posted on the doors of hospital rooms will flag the patient as having a history of violent behavior. The rings are being launched in conjunction with four mandatory learning modules that offer strategies for diffusing difficult behaviours and conflicts, and seeking assistance when needed.

Manitoba Nurses Union has also established the link between violence, as experienced by nurses, and the development of PTSD symptoms. As a result of MNU's efforts, only in Manitoba does presumptive legislation stipulate for the purposes of the Workers Compensation Board that if a worker suffers from post-traumatic stress disorder, the disorder must be presumed to be an occupational disease the dominant cause of which is the employment, unless the contrary is proven.

Ontario

Ontario Nurses' Association (ONA) is part of a three-year provincial Workplace Violence Prevention in Health Care Executive Committee and Leadership Table which was tasked with developing a comprehensive action plan. Their recent report makes 23 specific recommendations, including a minimum security and training standard and joint Ministry of Health and Labour promotion of the Public Services Health and Safety Association's Violence, Aggression and Responsive Behaviour Tools, as well as a quality improvement plan indicators for workplace violence.¹⁰²

In addition, ONA has expanded their *Nurses Know* ad and public awareness campaign regarding hospital funding and RN cuts, calling a code on health care in Ontario, which includes calling for a Code White to reveal the painful reality of workplace violence against nurses, whenever and wherever they are providing care. Ontario Nurses' Association also has set up a website www.violence.ona.org on which it shares resources and encourages nurses to share their stories of violence in the workplace. ONA has developed a Violence Prevention Toolkit with information and resources for its membership.

Recently, some charges are being laid by Ontario's Ministry of Labour against facilities which do not uphold their obligations under the *Occupational Health and Safety Act*, allowing violence against nurses to occur.

The Michael Garron Hospital's (formerly Toronto East General Hospital) collaboration with ONA to combat violence shows what can be done when employers commit to working with the union to combat violence. Among the comprehensive elements in place at the Michael Garron Hospital are strategic partnerships with a committed leadership and active union engagement as key stakeholders, workplace violence prevention (WVP) committees and numerous measures and procedures, widely posted zero tolerance signs, proactive external and internal risk assessments and two-way voice communication with security, a comprehensive patient flagging and alert system, incident reporting software, employee training, specially trained security and security measures, data collection, and support for employees when incidents occur. As a result of these measures, staff satisfaction and engagement has increased, and the severity of violent incidents has decreased. Further, patient outcomes have improved, and absenteeism has also declined, resulting in organizational benefits.¹⁰³



Nova Scotia

In 2015, the Nova Scotia Nurses' Union (NSNU) published *Broken Homes*, which documented the violence in the province's nursing homes and made recommendations to improve safety in the province's facilities for both patients and staff.¹⁰⁴ NSNU has also targeted violence in acute care emergency departments. In response to a troubling incident at a rural emergency department, and at the insistence of the NSNU, the Premier established a working group co-chaired by the NSNU and the Provincial Health Authority, to develop recommendations around improving safety in community emergency departments. The group developed a 12-point action plan which will be fully implemented by December 2017. NSNU is also launching ads to raise awareness among the public and its membership that violence is not an acceptable part of the job for nurses.¹⁰⁵

New Brunswick

As a result of a letter of intent in the collective agreement between the New Brunswick Nurses Union (NBNU) and the NB Association of Nursing Homes, the New Brunswick Nursing Home Workplace Violence Prevention Working Group – of which NBNU is a member – has been tasked with developing a violence prevention toolkit and identifying, developing and sharing training and resources to reduce incidents of violence in New Brunswick's nursing homes. It is encouraging all nurses to report violence when it occurs.

The NBNU also negotiated a letter in their collective agreement with New Brunswick's two health authorities, which covers nurses working in hospitals and community, to develop and implement comprehensive violence prevention

programs. In consultation with NBNU, Horizon, NB's English health authority, has developed and piloted a program which is being gradually rolled out Horizon-wide. Unfortunately, the pace of the roll-out is slow, and the program has been allotted limited resources. Vitalité, NB's French health authority, began meetings with representation from NBNU and the authority's upper management in late 2016 to improve and expand their violence prevention measures.

The NBNU is also lobbying the provincial government to specify that violence is a workplace hazard within the province's *OH&S Act* as New Brunswick is the only province that does not have OH&S-legislated protection against violence.

Prince Edward Island

The Prince Edward Island Nurses' Union (PEINU) is in the initial process of collecting data on violence in the workplace from members. An action plan announcement is planned for fall 2017.

Newfoundland and Labrador

Since 2015, Registered Nurses' Union of Newfoundland and Labrador (RNUNL) has partnered with employers and government to develop posters for an anti-violence campaign in health care sites across the province to raise awareness of the issue, as well as increase their efforts to educate RNUNL's branch leaders regarding bullying impacts and prevention.

8. CONCLUSION

A Call to Action

The Canadian Federation of Nurses Unions and its member organizations recognize that this discussion paper is the first step on a longer journey to eliminate violence in the health care sector. This paper paints a grim picture of the current reality with respect to violence in the health care sector and the resultant personal and financial toll on our health care system.

Since the *2005 National Survey of the Work and Health of Nurses*, the number of violence-related lost-time injuries for health care workers has increased dramatically; health care workers have also experienced an erosion of their mental health with high rates of burnout, compassion fatigue, depression, and PTSD symptoms. With the rising levels of acuity and complexity for patients in both the hospital, community and long-term care sectors, and ongoing concerns about safe staffing, this situation with respect to violence in the health care sector is likely to continue to worsen unless concerted action is taken now.

This paper is a Call to Action. 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, bullying, harassment and abuse – both verbal and physical – and that it is the responsibility of employers to try to mitigate, and ultimately eliminate, workplace violence hazards. Violence in the workplace impacts everyone – both staff and patients – and negatively impacts the quality of care and patient outcomes. Violence is extremely costly, affecting organizations' and employers' bottom line, and damaging health care workers wellbeing and quality of care for patients.

We know violence is increasing in our health care settings, and the factors that contribute to this increase. We know the workers that are most at risk, and we have positive examples of what works to help reduce violence against health care workers. As such, governments, employers, unions and other health care stakeholders must come together to take concerted action on the issue. Governments must provide meaningful and consistent enforcement of provincial OH&S legislation, and related federal legislation. Governments must also champion new legislation to help health care workers impacted by violence, PTSD and domestic violence; employers must provide leadership for systemic organizational change, acknowledging the impact of violence and the extent of the problem, speaking up to safeguard the health of employees and patients. Finally, unions and other health care stakeholders must speak as one voice to say unequivocally – Enough is Enough – we reject violence as 'just part of the job'.

Working together we can stop violence in health care.

“We must speak as one voice to say unequivocally – Enough is Enough – we reject violence as ‘just part of the job’.”

- CFNU President Linda Silas

CFNU Plan to Stop Violence in the Health Care Sector – 2017-2018

- Identify barriers, enablers, and potential policy and legislative levers.
- Work with member organizations to strengthen and improve OH&S legislation so as to create safe workplace standards for health care workplaces.
- Work with member organizations to ensure meaningful and consistent enforcement of OH&S legislation and consistent reporting, as well as strong language around the prevention of violence & bullying in health care workplaces, through risk assessments, education, training and emergency preparedness.
- Lobby for memorandums of agreement (with the Crown and police) to improve the process of investigating workplace safety incidents and the subsequent laying of criminal charges against patients who assault nurses.
- Lobby for charges to be laid under the federal Bill C-45 (The “Westray Bill”) for organizations and individuals who fail to ensure the safety of workers and the public.
- Lobby for amendments to the federal *Criminal Code* (section 269.01) to require a court to consider the fact that the victim of an assault is a health care worker to be an aggravating circumstance for the purposes of sentencing.
- Lobby to include health care workers and physicians in the PTSD presumptive legislation framework federally.
- Develop and deliver a communications strategy to bring national attention to the issue of violence against nurses.
- Host a national roundtable on violence in health care.
- Develop a national violence toolkit highlighting best practices in health care sectors.
- Conduct a national survey to obtain data on workplace violence from all provinces.

9. MESSAGE DE LA FCSII

Linda Silas, Présidente

Au cours des deux dernières décennies, nous, infirmières et infirmiers, avons observé une augmentation de la violence dans nos milieux de travail. Chaque jour, nous nous rendons au travail sachant que nous pourrions faire l'objet de violence verbale ou physique. Coups de poing, coups de pied, mots grossiers ou se faire cracher dessus, voilà à quoi sont confrontés les infirmières et les infirmiers de chaque secteur de la santé. Le temps est venu de dénoncer et de dire clairement et énergiquement : « la violence ne fait pas partie de notre travail! » C'est le message du document de travail de la FCSII *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*.

Le nombre de demandes d'arrêt de travail en raison de blessures liées à la violence chez les travailleurs de la santé de première ligne a augmenté de près de 66 % au cours de la dernière décennie, soit un taux d'augmentation trois (3) fois plus élevé que chez les agents de police et les agents correctionnels confondus. Selon le récent sondage mené par la FCSII sur la sécurité des patients et les conditions de travail du personnel infirmier, 61 % du personnel infirmier a fait l'objet d'un type de violence au cours des 12 derniers mois (intimidation, violence psychologique ou verbale, harcèlement sexuel ou en raison de la race, agression physique) mais, malheureusement, le quart seulement de ces personnes ont demandé l'aide de leur syndicat infirmier (et seulement 60 % l'ont signalé). Plus important encore, 66 % des infirmières et des infirmiers ont considéré quitter leur emploi au cours de la dernière année, soit pour travailler pour un autre employeur ou choisir une autre profession.

Les infirmières et les infirmiers aux premières lignes sont dans une marmite à pression. Tout augmente : populations plus élevées de patients, augmentation de l'acuité des besoins des patients, et augmentation des charges de travail, pendant que la qualité des soins diminue. La violence est un symptôme d'un milieu de travail malsain. Elle contribue à l'absentéisme chez le personnel infirmier en raison de maladie ou incapacité) : 9,0 % chez les infirmières à temps plein du secteur public en 2016, comparativement à 5,7 % (moyenne pour toutes les autres professions), En 2016, le coût annuel de l'absentéisme en raison de maladie ou incapacité est estimé, de façon conservatrice, à 989 millions \$ par année.

La position de la FCSII est que chaque travailleur de la santé devrait avoir le droit à la sécurité dans son milieu de travail et être à l'abri de tout type de violence, d'intimidation et de harcèlement, qu'importe la forme ou la source. Ce document est un Appel à l'action qui encourage les infirmiers et les infirmières à mettre un frein à la violence. Collectivement, en nous exprimant d'une seule voix forte, nous pouvons y arriver.

La FCSII demande aux gouvernements, aux employeurs, aux syndicats et autres intervenants du secteur de la santé de s'unir parce que nous voulons tous régler ce problème. Ce rapport ouvre la voie et recommande les mesures suivantes pour régler le problème de la violence.

Recommandations de la FCSII

Déterminer les politiques provinciales et les options législative, et lutter pour leur mise en place. Que la FCSII, et ses organisation membres, collaborent avec les gouvernements provinciaux et territoriaux :

- Pour renforcer et améliorer la législation en matière de santé et de sécurité au travail afin d'établir des normes assurant la sécurité des milieux de travail du secteur de la santé.
- Pour assurer une mise en application conséquente et le signalement régulier des incidents, ainsi qu'une formulation claire par rapport à la prévention de la violence et de l'intimidation dans les milieux de travail infirmiers, soit une formulation qui tient compte des évaluations des risques, de l'éducation, de la formation et de la préparation aux situations d'urgence.

Déterminer des politiques fédérales et des options législatives, et lutter pour leur mise en place. Que la FCSII, et ses organisation membres, collaborent avec le gouvernement fédéral :

- Pour assurer que des accusations soient portées, lorsque cela s'avère pertinent, en vertu du projet de loi C-45, connu aussi sous le nom de projet de loi Westray (section 217.1 du Code criminel), contre les organisations et les personnes qui n'assurent pas la sécurité des travailleurs et du public.
- Pour amender le Code criminel fédéral (section 269.01) afin d'exiger qu'un tribunal considère comme circonstance aggravante le fait que la victime de l'agression soit un travailleur de la santé.
- Pour inclure les travailleurs de la santé et les médecins de partout au Canada dans la structure fédérale du projet de loi relatif au TSPT.

Déterminer les complices potentiels et forger des alliances. Que la FCSII et ses organisations membres :

- Élaborent des mémorandums d'entente avec la Couronne et la police pour améliorer le processus d'enquête des accidents du travail, et facilitent le processus pour que des accusations criminelles soient portées contre les patients qui agressent un membre du personnel infirmier.
- Organisent une rencontre avec les ministres de la Santé FPT pour parler d'une campagne dont le thème serait : « la violence ne fait pas partie du travail ».

Être chef de file par rapport à la prévention de la violence, à l'élaboration de ressources nationales, et à la collecte de données. Que la FCSII et ses organisations membres :

- Organisent une table ronde nationale sur la violence dans le secteur de la santé.
- Élaborent et diffusent une stratégie de communication afin d'attirer l'attention, à l'échelle du pays, sur le problème de la violence envers le personnel infirmier.
- Mettent en lumière les pratiques exemplaires dans les secteurs des soins de santé grâce à une trousse nationale de prévention de la violence.
- Mènent un sondage à l'échelle du pays pour recueillir des données de chaque province sur la violence au travail.

En qualité d'infirmières et d'infirmiers, nous voulons prendre soin de nos patients et les aider à guérir. Lorsque nous faisons l'objet de violence, et de ses répercussions physiques et psychologiques, notre capacité à dispenser des soins de qualité est affectée. La violence joue un rôle dans le burnout, l'usure de compassion, la dépression et le TSPT, et cela nuit à notre capacité de dispenser des soins de qualité et protéger la santé et le bien-être de nos patients. Comme nous l'a rappelé le juge Archie Campbell qui a présidé la Commission sur le SRAS en Ontario : si les travailleurs de la santé ne sont pas en sécurité, les patients ne le sont pas non plus. Si l'industrie minière peut mettre en application des normes strictes en matière de santé et de sécurité au travail afin d'assurer la sécurité des travailleurs, alors nous, en qualité d'infirmières et d'infirmiers, méritons aussi des milieux de travail qui ont une tolérance zéro par rapport à la violence.

Le changement ne se fera pas facilement. Nous travaillons dans des milieux où la violence est normalisée. Et où d'autres infirmières peuvent nous dire de « l'avalier ».

En qualité d'infirmières et d'infirmiers, nous rejetons l'idée que la violence « fait simplement partie du travail », et nous allons faire partie de la solution!

- Linda Silas, Présidente de la FCSII

Nous avons besoin d'un changement radical à la culture des milieux de travail infirmiers. Il faut passer d'une culture qui réagit à la violence après coup à une culture qui fait la prévention de la violence avant qu'elle n'arrive. Pour que cela se concrétise, nous allons devoir collaborer – gouvernements, employeurs, syndicat et, oui, personnel infirmier. Pour les infirmières et les infirmiers aux premières lignes qui doivent gérer la violence, le changement commence avec eux, à chaque jour, lorsqu'ils se rendent au travail.

À quoi ressemble un changement de culture positif?

Le rapport présente l'exemple de l'Hôpital Michael Garron en Ontario (anciennement Hôpital général Toronto East) qui a mis en place un programme de prévention de la violence, élaboré en collaboration avec l'Association des infirmières et des infirmiers de l'Ontario. Parmi les principales caractéristiques, mentionnons une formation complète aux premières lignes, signalement, évaluations préventives des risques, meilleures technologies de communication, meilleure élaboration de plan de soins pour les patients ayant des antécédents de comportements violents, ainsi qu'un personnel de sécurité formé adéquatement et offrant du soutien. Le résultat est une culture de travail proactive et réceptive. Ce n'est peut-être pas parfait – certes, il faut faire davantage – mais cet exemple est une feuille de route pour amorcer le changement. Il illustre ce qui peut être accompli lorsque les employeurs et les syndicats collaborent pour amorcer un changement systémique dans le but de prévenir la violence dans les milieux de travail infirmiers.

J'aimerais remercier Carol Reichert, auteure de *Enough is Enough: Putting a Stop to Violence in the Health Care Sector*, l'équipe de projet de la FCSII, et les membres du réseau de la FCSII en matière de santé et de sécurité au travail, notamment Dewey Funk (IIUA), Denise Dick (SIIS), Tom Henderson (SIIM), Erna Bujna (AIO), Jennifer Dickison (SIINB), et Paul Curry (SIINÉ), pour leur contribution à ce rapport qui se veut un Appel à l'action pour la FCSII, ses organisations membres et les infirmières et les infirmiers de partout au Canada.

En qualité d'infirmières et d'infirmiers, nous rejetons l'idée que la violence « fait simplement partie du travail », et nous allons faire partie de la solution!

Toujours solidaire,



Linda Silas
Présidente de la FCSII

10. EXECUTIVE SUMMARY (FRENCH)

La violence augmente dans le secteur de la santé; la violence – qu'elle soit verbale, physique ou les deux – est chose quotidienne dans nos établissements de santé d'un océan à l'autre. Dans les hôpitaux de l'Ontario seulement, le coût de la violence se chiffre à 23,8 millions de dollars par année, et représente 10 % des absences résultant de blessures. Le manque d'effectifs, la dotation inadéquate, le peu de sécurité, l'augmentation du nombre de patients, ainsi que l'augmentation de l'acuité et de la complexité des besoins des patients, sont tous des facteurs qui contribuent à diminuer la sécurité des patients et du personnel. La situation est particulièrement problématique dans les salles d'urgence et les établissements psychiatriques. Les salles d'urgence sont aux premières lignes des soins de santé. Puisque n'importe qui peut y entrer facilement, les risques sont inconnus et difficiles à évaluer. Les patients des salles d'urgence sont stressés, ressentent souvent de la douleur, et doivent gérer de longs délais d'attente dans des salles surpeuplées. Les policiers y amènent souvent des personnes impliquées dans des altercations, sous l'effet de la drogue, ou souffrant de maladies mentales, et les laissent aux mains du personnel des urgences. Les établissements ou services psychiatriques, qui s'occupent de patients ayant des problèmes de santé mentale, présentent aussi un potentiel élevé de violence. Finalement, dans les établissements de soins de longue durée, la violence se vit au quotidien, surtout si les effectifs infirmiers ne se sont pas harmonisés à l'augmentation du nombre de patients – souvent une ou deux infirmières pour dispenser des soins à 100 personnes – ni à l'augmentation de l'acuité des besoins des patients.

Les répercussions de la violence, de l'intimidation et de la violence conjugale au travail affectent tous les infirmières et les infirmiers et le milieu de travail. Elles contribuent au nombre élevé de blessures entraînant un arrêt de travail. Les statistiques 2015 de l'Association des commissions des accidents du travail du Canada (ACATC) sur les absences résultant de blessures indiquent que les secteurs des services de santé et des services sociaux sont au sommet de la liste avec 41 111 blessures ayant entraîné un arrêt de travail, ce qui représente 18 % des absences en raison de blessures. Ce record

peu flatteur a été maintenu par le secteur des services de santé et des services sociaux depuis plusieurs années. En 2015, le nombre d'absences en raison de blessures avait plus que doublé chez les travailleurs de la santé de première ligne, comparativement aux policiers et aux agents de correction confondus. Plus important encore, pendant que le nombre d'absences en raison de blessures chez les policiers et les agents de correction confondus est demeuré relativement stable au cours de la dernière décennie, le nombre d'absences en raison de blessures chez les travailleurs de la santé de première ligne continue d'augmenter d'une année à l'autre (voir Tableau 1). Les blessures entraînant un arrêt de travail contribuent aux taux élevés d'absentéisme chez le personnel infirmier du Canada. En 2016, le taux d'absentéisme chez le personnel infirmier à temps plein du secteur public était de 8,8 %, soit un taux substantiellement plus élevé que le taux moyen pour les autres professions (6,7 %). Le coût annuel est estimé à 989 millions de dollars.

Bien que l'on soit de plus en plus conscient du problème de la violence dans les établissements de santé au Canada, la législation, les politiques, les pratiques et la mise en application accusent un retard. La violence est un danger professionnel. Toutes les lois en matière de santé et de sécurité au travail des provinces, sauf du Nouveau-Brunswick, le reconnaissent. Selon la FCSII, les employeurs devraient déployer des efforts pour diminuer et, ultimement, éliminer tout type de violence. Les infirmières et les infirmiers ont le droit de travailler dans un milieu exempt de tout type et de toute source de violence, d'intimidation, de harcèlement, de violence verbale qu'importe la source (patients, familles, médecins, collègues, gestionnaires) ou l'origine (à l'intérieur ou à l'extérieur de l'établissement). La violence au travail a un impact sur le personnel et les patients. Elle affecte la qualité des soins et a un impact négatif sur les résultats de santé. Comme l'a si bien énoncé le juge Archie Campbell, qui a présidé la Commission d'enquête sur le SRAS en Ontario, "si les travailleurs ne sont pas protégés contre les risques à la santé et à la sécurité, les patients et le public ne sont pas protégés non plus." Des milieux de travail dangereux et violents sont dangereux pour tous.

Selon les études, la situation par rapport à la violence et à l'intimidation s'est envenimée au cours des deux dernières décennies. Malheureusement, parce que les agences gouvernementales pouvant mener une enquête approfondie sur la santé du personnel infirmier n'ont pas agi pendant plus d'une décennie, la FCSII doit combler le vide et dresser un portrait fragmenté des milieux de travail rongés par la violence. Une image émerge des données disponibles, une image montrant le personnel infirmier faisant l'objet de violence physique et verbale sur une base régulière, ce qui engendre un milieu dangereux pour le personnel infirmier et des risques potentiels à la santé et à la sécurité des patients. Tous les travailleurs de la santé sont affectés par l'augmentation de la violence dans les établissements de santé, et les taux de violence sont liés à la durée du contact avec les patients. Par conséquent, et par définition, le personnel infirmier réglementé et les aides-infirmières courent le plus grand risque de faire l'objet de violence.

Nous savons que la violence est présente – nous savons quels travailleurs sont le plus à risque – et nous avons des exemples positifs de mesures qui aident à diminuer la violence envers le personnel de la santé. Par conséquent, il est déplorable de voir que les gouvernements n'agissent pas de façon concertée à cet égard. En l'absence d'une mise en application musclée et régulière de la législation provinciale en matière de santé et de sécurité au travail, et de la législation fédérale connexe (projet de loi C-45), plusieurs employeurs refusent de reconnaître l'ampleur du problème, et certains imposent le silence au personnel infirmier. En qualité d'infirmières et d'infirmiers, nous ne serons pas réduits au silence; nous allons prendre la parole et dénoncer les actes de violence.

L'énoncé de position commun de la FCSII et de l'Association des infirmières et infirmiers du Canada sur la violence et l'intimidation demande la tolérance zéro par rapport à la violence au travail dans le secteur de la santé. On peut y lire qu'il est « inacceptable de financer, d'administrer et de gérer un système de santé offrant un milieu de travail malsain, ainsi que d'y travailler ou d'y recevoir des soins ». Pour les besoins de ce texte,

la violence est définie comme l'exercice d'une force physique par une personne, et contre un travailleur, dans un lieu de travail, et qui entraîne ou peut entraîner une blessure physique à la victime; la violence peut aussi prendre la forme de violence verbale. La violence physique et la violence verbale ont des répercussions psychologiques et émotionnelles. L'énoncé de position commun de la FCSII et de l'AIIIC sur la violence et l'intimidation définit l'intimidation comme un « harcèlement psychologique général »; l'intimidation est une « forme d'agression physique et de maltraitance ». Les taux élevés d'intimidation dans le secteur des soins de santé sont un défi pour les services des ressources humaines et les employeurs qui tentent de maintenir en poste un nombre limité de ressources.

En l'absence de données suffisantes et complètes sur la violence envers les travailleurs de la santé du Canada, et à la lumière des approches fragmentées pour régler le problème, ce document vise à combler l'écart en racontant le vécu des personnes les plus touchées, notamment les infirmières et les infirmiers de première ligne. Ce document vise à déclencher une discussion nationale sur la violence dans le secteur de la santé, une discussion qui rassemble les expériences disparates d'un océan à l'autre, et qui met en relief l'étendue et l'intensité des répercussions de la violence au travail. De plus, ce document représente un appel à l'action à l'échelle nationale. En qualité de fédération nationale des syndicats infirmiers, représentant près de 200 000 professionnels de la santé de première ligne, et étudiants en sciences infirmières, la FCSII demande aux gouvernements, aux employeurs, aux syndicats et au personnel infirmier de première ligne de collaborer pour mettre fin à la violence dans le secteur de la santé. La violence ne devrait jamais « faire partie du travail »!

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