BRIEF

CANADIAN NURSES ASSOCIATION®

VIOLENCE FACED BY HEALTH-CARE WORKERS IN HOSPITALS, LONG-TERM CARE FACILITIES AND IN HOME CARE SETTINGS

Brief prepared for the Standing Committee on Health

May 16, 2019

The Canadian Nurses Association is the national and global professional voice of Canadian nursing, representing 135,000 nurses in all 13 jurisdictions across Canada. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.

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Introduction

Violence in the health-care sector is not a new problem. It is a widely recognized global issue (Bloom, 2019; Edward et al., 2016; Spector, Zhou & Che, 2014) with one-third of nurses worldwide reporting being victims of physical assault, two-thirds being exposed to non-physical violence at work, and 80% being victims of some form of workplace violence (Chang, Lee & Wang, 2018; Nowrouzi-Kia, Isidro, Chai, Usuba & Chen, 2018). Statistics show that 60% of new nurses who experienced workplace violence will resign from their first place of work within six months of employment (Bloom, 2019) and of these nurses, 50% will choose to leave the profession altogether (Hubbard, 2014). There is also a marked difference in the incidence of reported cases between nurses and other sectors. For example, 61 per cent of nurses report having experienced abuse, harassment or assault in the workplace in the past 12 months compared with only 15 per cent of Canadian employees in other sectors during the previous 24 months (CFNU, 2017). In Ontario, there were 808 lost-time injuries in the health-care sector due to workplace violence, greatly outnumbering other sectors that were surveyed, including manufacturing (138), construction (3), and mining (0) (WSIB, 2016). Although these numbers show an alarming situation, it is actually much worse; only 19% of nurses formally report workplace violence (Nowrouzi-Kia et. al., 2018).

Underreporting workplace violence is a serious problem that poses barriers to improving conditions. The true extent of the issue is not known, making it impossible to manage the problem and distribute preventive resources effectively (Arnetz et al., 2015). There are several reasons behind underreporting, including lack of visible injury and time; time-consuming reporting systems; lack of peer and management support; fear of reprisal or being blamed for the incident; and feeling that the reporting won't bring any changes (Kosny et al.,2018). The most alarming cause of underreporting is the common belief that violence is "part of the job" — leading to a conspiracy of silence within health-care settings. Also, health-care workers are often reluctant to report verbal and psychological abuse, especially when it is perpetuated by a supervisor (Arnetz et al., 2015).

While all nurses are at risk of workplace violence, we know that nurses working in long-term care, emergency departments and psychiatric settings may be at a higher risk, as are night-shift workers and novice nurses (Nowrouzi-Kia et. al., 2018; Spector et al., 2014). Perpetrators of workplace violence include patients, patients' family or visitors, doctors, managers, and other nurses and employees (Edward et al., 2016). Different factors contribute to violence perpetrated by patients, families and health-care professionals, requiring different strategies to alleviate it.

The work environment is also known to contribute to workplace violence. Examples of organizational factors that contribute to the problem include excessive workloads, inadequate staffing, excessive use of overtime (mandatory and/or voluntary), lack of managerial support when reporting instances of workplace violence, and lack of perceived consequence when committing violent acts (CFNU, 2019; Nowrouzi-Kia et. al., 2018).

The issue of workplace violence has been discussed, researched and documented at length for the past 15 years. Several initiatives to alleviate the problem have also been implemented in various settings. However, it is not clear how successful these are, as evaluations of such initiatives are seldomly done or published. Regardless of everything we know and do, the incidence of aggression within health-care organizations has been trending upwards (Edward et al., 2016).

Background

What do we mean by "workplace violence" in health care?

Part of the problem is that definitions of what constitutes "workplace violence" vary and are still debated. Also, many words are used interchangeably to describe these events — for example violence, aggression, bullying, harassment — which makes it difficult to gather and compare statistics or even discuss the issue. A commonly used typology to classify episodes of workplace violence is that of Courcy (2004). This typology includes four categories: physical, psychological, sexual and financial. In addition, workplace violence can be horizontal and vertical.

Physical violence can be defined as the "exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker" (Occupational Health and Safety Council of Ontario, 2010, p. 3). This type of violence includes actions such as biting, kicking, shoving, scratching, pinching, spitting, slapping and punching.

Psychological violence includes harassment, bullying, intimidation and demeaning treatments. Examples of such aggression include controlling behaviours, stealing credit for one's work, rudeness, abusive language, humiliation, excessive scrutiny and rumouring (Blackstock, Salamic & Cummings, 2018; St-Pierre, 2010).

Sexual harassment is a form of discriminatory harassment, and must include three elements: unwanted sexual behaviour, which manifests itself repeatedly, and which has harmful consequences on the victim (Institut national de santé publique, 2012).

Financial violence can be defined as "actions taken to prevent advancement or promotion or to a situation that may have a financial impact." (Courcy & Savoie, 2003)

Horizontal violence is most generally covert psychological violence perpetuated by workers to other workers of the same professional status (Blackstock et al., 2018).

Vertical violence is also most frequently covert psychological violence, but it occurs between workers at different levels in an organization's hierarchical system — including management (Cantey, 2013).

In light of the above, there is a need for more standardized language to describe the problem. Furthermore, it is still debated as to whether "intent" should be considered as part of the definition (e.g., should someone suffering from an impaired cognitive process, such as dementia, who hits health-care professionals be accused and charged with violence?) (Ferns & Chojnacka, 2005).

The consequences of workplace violence

The relationship between the apparent severity of the act (e.g., physical violence vs. psychological violence) and the impact it has on the victim is very complex and often unclear (Lanctôt & Guay, 2014). The consequences, however, are real. Workplace violence contributes to poor recruitment and retention of staff, professional exhaustion, anger, cynicism, negative behaviours, depression and anxiety (Edward et al., 2016). Physical injuries, somatic disorders, post-traumatic disorders, burnout, anger management issues, desire for revenge, persistent fear and anxiety are only a few of the most reported consequences experienced by victims (Lanctôt & Guay, 2014).

Horizontal violence leads to high staff turnover, increased illness and sick leave, decreased productivity, job dissatisfaction, decreased quality of care for patients, and increased cost on the health-care system (Bloom, 2019; Chang et al., 2018; Nowrouzi-Kia et al., 2018). Horizontal violence has the longest-standing effect on workers' emotional well-being (Bloom, 2019) while vertical violence is the most damaging (Lanctôt & Guay, 2014).

Addressing workplace violence for health-care workers: examples of what is available

In 2014, CNA and the Canadian Federation of Nurses Unions (CFNU) issued a **joint position statement** that clearly highlights the following:

- All nurses have the right to work in a respectful environment that is free from any form of violence and bullying, and these acts are not tolerated as part of a nurse's job.
- Every workplace should have a culture that promotes and cultivates respect.
- The promotion of violence- and bullying-free workplaces is a shared responsibility among all health-care stakeholders: employers; clients; nurses, nursing students and other employees in the health-care setting; nurse educators and researchers; governments/agencies; and nursing professional, regulatory, labour and accreditation organizations. Each of these stakeholders can play important roles in promoting and achieving violence-free workplaces.

CFNU (2019) offers a **toolkit** intended to centralize resources, research and information on workplace violence. The toolkit includes an interactive map of Canada listing the provincial and territorial legislation for each type of violence. The Ontario Ministry of Labour (2017) proposes numerous **recommendations** and a toolkit for system enhancements; these recommendations include increased support for patients with known aggressive behaviours; workplace violence policies in hospital quality improvement plans; and a reporting system for patients, families and staff to provide input on violent behaviours and their triggers.

Interventions have also been implemented in several health-care organizations. For example, 87% of institutions in Ontario have put in place reporting systems to monitor and address workplace violence (Health Quality Ontario, 2018). Nova Scotia has implemented a safe handling program aimed to bring awareness to the importance of scanning the environment for safety hazards (CFNU, 2019). Toronto has leadership engagement programs, active workplace violence committees, and workplace violence prevention programs (CFNU, 2019). Many workplaces in British Columbia have implemented monthly 60-second huddles about workplace violence prevention (CFNU, 2019).

While numerous research studies aiming to identify emerging best practices on the matter are being conducted, existing studies that have focused on interventions to reduce workplace violence have highlighted the unlikelihood of finding a simple, one-size-fits-all solution.

CNA's recommendations

- That the federal government lead a **pan-Canadian strategy** with the following objectives:
  - To study why, in light of everything we know and do, workplace violence continues to be an issue, including why initiatives continue to have limited success. This study may include conducting consultations, roundtables and a public inquiry seeking feedback from politicians, senior leaders, health-care professionals, patients and families.
  - To provide clear, more targeted, definitions of workplace violence to move toward a common language to allow comparison of data.
- That the federal government create a **hub** for proven best practices and information-sharing opportunities for organizations to learn from one another's experiences in preventing and addressing the issue.
- That the federal government support **funding** to evaluate existing programs and strategies as well as develop a longitudinal research program on workplace violence. These evaluations should focus on (1) learning from incidents and near misses; (2) what health-care professionals say is effective in their organizations; and (3) ensuring that polices pertaining to workplace violence are having the intended "on the ground" consequences.
- That the federal government **collaborate** with provincial and territorial health ministries and health-care organizations to develop prevention strategies that take into account individual characteristics, interpersonal factors and organizational factors. Such strategies could include, for example, minimum system enhancement initiatives related to health human resources, communication and work environments.

Conclusion

CNA is calling on the federal government to invest in a pan-Canadian strategy to study why current measures are not successful in reducing workplace violence in the health-care sector. This initiative will bring clarity to the issue and permit system enhancement strategies. With an upward trend in the number of workplace violence incidents in health care, CNA believes that workplace violence requires immediate federal government action as well as support for the victims. By adopting the recommendations in this report, the standing committee can address the growing need for prevention, evaluation and intervention pertaining to workplace violence in the health-care sector.

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