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Breaking Point: Violence Against Long-Term Care Staff

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Abstract

Direct resident care in long-term care facilities is carried out predominantly by personal support workers and registered practical nurses, the majority of whom are women. They experience physical, verbal, and sexual violence from residents on a regular basis. To explore this widespread problem, fifty-six staff in seven communities in Ontario, Canada, were consulted. They identified such immediate causes of violence as resident fear, confusion, and agitation and such underlying causes as task-driven organization of work, understaffing, inappropriate resident placement, and inadequate time for relational care. They saw violence as symptomatic of an institution that undervalues both its staff and residents. They described how violence affects their own health and well-being—causing injuries, unaddressed emotional trauma, job dissatisfaction, and burnout. They outlined barriers to preventing violence, such as insufficient training and resources, systemic underfunding, lack of recognition of the severity and ubiquity of the phenomenon, and limited public awareness.

Keywords

occupational violence, personal support workers, nurses, long-term care, body mapping

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Introduction

> I've had muscles pulled in my neck. I've been grabbed by the wrist and fingers. I've been groped—breasts and perineum. I've been kicked. I've been scratched. Last night I got punched in the back. I've had shoes, hats, everything thrown at me. There's not a day that I haven't been abused whether it's verbal or physical. Ever.

This study, undertaken in Ontario, Canada, was designed to explore the pervasive problem of violence against long-term care (LTC) workers. LTC facilities, which were formerly referred to as homes for the aged or nursing homes, house and care for residents who are unable to live independently, and they now include adults of all ages. While the media report regularly on incidents of resident-on-resident violence and on caregiver-on-resident violence, little has been written about the much more prevalent assaults against caregivers.[1] Type II violence, which is defined as "physical or verbal assault of an employee by a client/family member or customer,"[2] is the most common type of workplace violence in the healthcare setting.[3] It is such a widespread institutional phenomenon, that it has been referred to as an "epidemic public health problem."[4]

A previous study by the authors regarding violence in a wide range of healthcare settings in Ontario identified understaffing, underfunding, inadequate legislative and institutional protections, and a lack of public awareness as contributing factors.[5]

In a comprehensive Canadian study of violence in LTC, Banerjee et al. found that 90 percent of Canadian caregivers had experienced "physical violence from residents or their relatives and 43 percent reported physical violence on a daily basis." When compared to their Scandinavian counterparts, Canadian staff were six times more likely to experience physical assault.[6] In a Danish study, it was estimated that nursing home care workers are twenty-three times more likely to be at risk of aggressive behaviors than staff in other healthcare facilities.[7]

Women make up the majority of healthcare personnel. Many are working part-time or on an on-call basis.[8] The risk of violence, and sexual harassment, in particular, is higher for women and "it can be extremely high for women who are especially vulnerable such as those in precarious, low-paid, low-status jobs."[9]

There are additive and cumulative effects related to the threat of injury from angry or agitated residents, the distress caused by assault, verbal abuse, and sexual harassment. These stressors compound the harm caused by lifting and other strains, shift work, occupational stress, and workload in healthcare.[10] Further, caring for people who are unable to care for themselves is a physically and emotionally demanding job. LTC staff report high levels of burnout and emotional exhaustion.[11]

While there are many definitions for workplace violence, the European Commission has adopted the following: "Incidents where staff [members] are

abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health."[12] The American Academy of Experts in Traumatic Stress includes "near misses" and "fear of assault or witnessing an assault on a co-worker" in its definition.[13]

The issue of violence becomes complicated in the context of LTC where many of the perpetrators are cognitively challenged. The Ontario Long Term Care Association (OLTCA) calls aggressive actions "responsive behaviors" because the resident is often reacting to a "trigger in their environment." The OLTCA claims that, "Aggression implies malicious intent, and this is rarely the case."[14] Whether there is intent to cause harm and whether or not offenders have full understanding of the consequences of their actions, assaulted staff can nevertheless be as negatively affected as if the assaults were deliberate.

There have been significant changes in the character of LTC over the last two decades. Residents now require higher levels of care. Until recently, elderly residents made up the majority of the population of LTC homes. Now, residents include physically and mentally challenged adults of all ages, and 18 percent of residents are less than seventy-five years of age.[14]

In 2010, the criteria in Ontario for admission to LTC were changed. New residents were required "to have high or very high physical and cognitive challenges to qualify for admission."[14] Ninety percent of residents now have some level of cognitive impairment "with one-third severely affected." Forty percent suffer from mood disorder and 46 percent exhibit ". . . aggressive behavior related to their cognitive impairment or mental health condition."[14]

Although universal healthcare is provided in Canada, the private sector is becoming increasingly involved. In Ontario, where this study was conducted, 57 percent of LTC facilities are privately owned and operated, 24 percent are nonprofit/charitable, and 17 percent are municipally run. All receive some government funding, but residents are expected to contribute financially.[14]

Consulting With LTC Staff

The Ontario Council of Hospital Unions (OCHU) has grown increasingly concerned about workplace violence. Its members include many of the registered practical nurses (RPNs), personal support workers (PSWs), dietary, housekeeping, and other healthcare staff working in LTC facilities represented by the Canadian Union of Public Employees (CUPE). CUPE is the largest public-sector union in Canada representing healthcare workers employed in LTC, hospitals, home care, and other health services.

Method

OCHU/CUPE sponsored a collaborative effort with the authors in order to explore its members' experiences of violence on the job and to document their

ideas for preventing violence. Data were collected through group interviews. Data collection was assisted by a LTC staff person who is a member of OCHU/CUPE. She was granted a research fellowship by the University of Stirling, the host university, to recruit participants, organize interview dates and locations and collect participant work history and contact information. Between 2016 and 2018, ten group interviews were conducted with fifty-six LTC staff in seven communities of various sizes including three large urban centers with a broad demographic make-up. The study aimed to identify: workers' perceptions of the risk factors for violence against staff in the LTC environment; effects they personally experienced when subjected to violence; prevention strategies that could be adopted by employers and regulatory agencies to reduce the incidence and harmful effects of violence; and barriers to prevention efforts as well as to mitigating the effects of violence. Ethics approval was provided by the host university. All participants provided informed consent and agreed to protect each other's privacy.

A descriptive qualitative approach, which aims to summarize "events in the everyday terms of those events,"[15] was used to explore the issue of violence against LTC staff from the perspective of the population at risk. The research design provided a comprehensive exploration of the causes and effects of violence as well to determine possible preventive measures born out of the experience and opinions of those providing care in the field.

Study participants were recruited with the assistance of their local union executives. Some were specifically invited because they had reported violent incidents; however, an open invitation was made to anyone who wished to participate. Interviewed groups ranged in size from four to eight participants representing various healthcare occupations, communities, ages, genders, ethnic groups, and years of experience. Group composition was arranged with the understanding that a wide range of participants enhances the reliability and transferability of the findings.[16]

Overall, the researchers consulted with twenty-nine PSWs, fourteen RPNs, five cleaners/housekeepers, three dietary staff, three healthcare aides, two clerical staff, two Behavioral Supports Ontario (BSO) staff, and one recreational therapy assistant. Forty-nine participants were women and seven were men. Although statistics regarding the ethnic make-up of LTC workers in Ontario are unavailable, several groups were represented in this study. Forty-seven of the participants self-identified as Caucasian, Canadian, or European immigrants, four as Black or African-American, three as Filipino, and one as Asian. Interview group participants represented employees from thirteen facilities in communities across the province. In addition, several participants spoke of violence they had experienced during previous employment in other healthcare facilities in Ontario as well as in-home healthcare positions. There was an age differential between the youngest at twenty-two and oldest at sixty-six years; the average age was forty-eight years. The average work experience was twenty years and ranged from one to thirty-eight years. All but three of the

participants, two dietary staff and one clerical staff, had personally experienced violence—most on a regular basis.

The group interviews, lasting from two to three hours, were semistructured to allow for interaction, elaboration, and the discovery of information that may not have been previously considered by the researchers.[17] Open-ended questions were used to gather the experiential data.

Each group interview began with a body-mapping exercise. Body mapping in a group environment is effective when there is an anticipated advantage to interaction among participants. Body mapping is essentially a simple health survey instrument that uses large outlines of the human body posted on a wall or flip chart, marking pens, and/or stickers to elicit and record responses. Two separate images, labeled, "Front" and "Back," are posted. A cloud is drawn over the head to represent mental or emotional issues, such as stress symptoms or anxiety.[18–20] Participants were asked to approach the body maps together and apply color-coded stickers to areas where they had personally been affected by physical, verbal, and/or sexual violence. Different colors and shapes of stickers were used to denote the severity of the assaults and their effects (see Figure 1). They talked casually among themselves as they completed

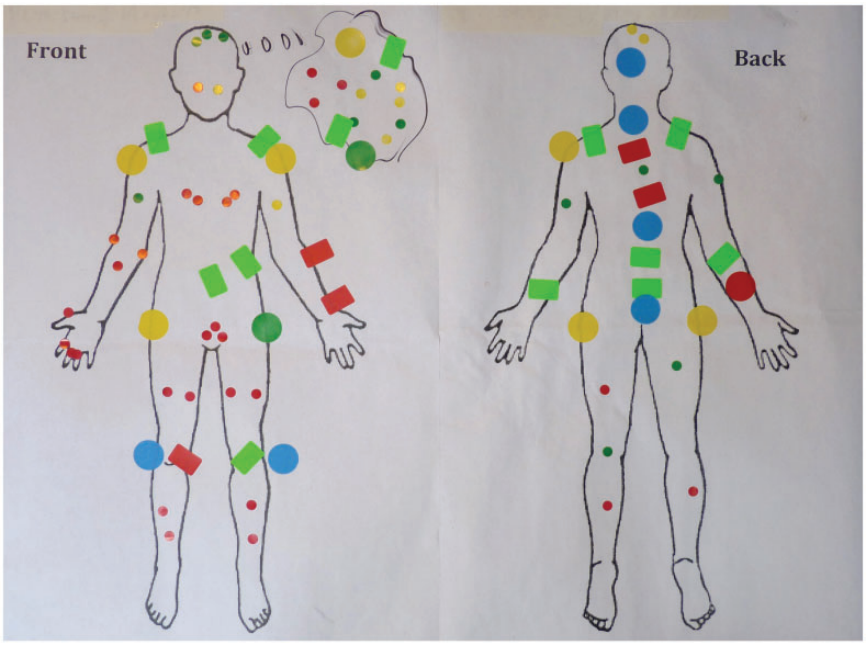

Figure 1. A Body Map from one of the group interviews displaying assaults experienced by participants. Large circles represent serious injuries, rectangles moderately serious injuries, and small dots minor injuries. The stickers in the cloud represent psychological impacts.

the exercise and then were reassembled to describe what their stickers represented. A broader discussion grew from these personal stories of violence, prompted by probing questions from the researchers. This dialogue was audio recorded and transcribed.

Analysis

Responses were analyzed using a thematic qualitative approach providing insight into individual experiences and the contextual environment. Using a qualitative data analysis program, Dedoose,[21] data were indexed through systematic coding procedures that facilitated the creation of a structured codebook in which a list of themes was extracted from analysis of the interview transcripts. A comprehensive table was created consisting of the codes and excerpted interview passages illuminating the emergent themes.[22,23]

Results

Findings are organized under the major category heading of Personal Effects, Risk Factors, Solutions, and Barriers. Numerous brief excerpts reflecting key themes have been integrated into the findings with the assumption that participants' own words can more accurately convey their personal experiences and feelings than authors' interpretations.[24] Some passages have been marginally edited for clarity or to protect the identity of the participants.

Personal Effects

Violence can cause a range of ills. Physical injuries range from minor and temporary to debilitating and permanent. Psychological consequences include fear, self-blame, trauma, and powerlessness and can be life-changing and long lasting.[25]

Clusters of stickers were applied to the body maps in the groin, breast, and buttock areas, which represented groping, touching, grabbing, or sexual assault. The arms and face were also shown as common targets for slapping, grabbing, spitting, scratching, or wrenching. Stickers on the head represented blows resulting in minor assaults to serious concussions. Numerous other stickers were applied throughout the body images.

In explaining the stickers, participants described a wide range of physical assaults resulting in eye and ear injuries, bruises, burns, scratches, and fractures.

- On a daily basis I am hit, punched, spat at, sworn at, slapped, bitten. I've had hot coffee thrown at me. I've gone home with burns on my hands.
- I had a fractured tailbone after being run over by an electric wheelchair.
- I rolled him towards me and he grabbed onto my breast so hard. I didn't know how to get him off but pulling made it worse. My breast was black and blue.

- I put his pyjamas on and I went to tie them. Then I saw his fist. Oh, my God! Here it comes. Pow, right in the mouth. It cracked all my teeth and broke my nose.

Facilitators asked participants to elaborate on how they as individuals were affected by all this violence. Some had been so seriously injured they were off work or placed on modified duties for an extended period of time.

- This resident was in a chair and I was just walking by. He grabbed my arm and turned me around his chair and pulled me up and over. I had bruises on my ribs and he sprained my wrist. I was in physiotherapy for weeks and I still have pain.
- She pushed back as I lost my grip and I slipped. Something popped in my back. I had nobody to call for help. I felt like, "Oh my god, now I can't do my work. Now they're going to be short staffed that day." I finished her care in excruciating pain and then sat down and just broke into tears. I was off work for months.

Several participants in each group applied stickers in the cloud above the head representing stress, burnout, anxiety, depression, and fear, as well as the effects of racist, sexist, classist, or anti-immigrant comments.

- I'm still not the same nurse that I used to be. There are such lasting effects. It's not just over when the bruises heal.
- The next day when I went in, I knew I'd be going into the room with the man that chased me down the hall. It all started coming back and I was on guard. You can't give good care that way. You don't want to get that swat in the head.

They talked about how sexist and racist comments and sexual touching leave them feeling hurt, angry, and demoralized—and seemingly with no recourse.

- "You've got a nice set of tits on you." I get that all the time, or they grab my butt. It's degrading. There are times that you just sit down in your car and cry.
- She had a southern drawl and used to say, "Oh you. I had slaves like you."
- "Oh, an immigrant. Where did they find you? Downtown? Brought you here?"
- He groped me when I was bathing him. It bothered me for a very long time, but I didn't dare say anything because I was worried about my job. I was a single mom and I had to work.

Others were troubled by witnessing coworkers being abused or injured by residents.

- I was helping a coworker. She was black, and the resident was white. And he just came out with words like, "Why don't you __ me?" Calling her the

n-word, the f-word and saying "Do this to me. That's what you're getting paid for." He called me "Chink."

When residents engaged in violent actions against other residents, staff who intervened would also be at risk.

- I had a scary experience during my first pregnancy. I put myself between a resident that was being punched in the face repeatedly by another resident. Both of them had dementia.
- My coworker couldn't sleep for a week after seeing that beating. All she could see was the residents coming down the hall. One man was covered in blood and the other man had black eyes and a bloody nose and had his ear half chewed off by the other resident. And then the resident that did the beating climbed over the desk and went after her.

Timely and appropriate support and intervention have been shown to decrease the likelihood of ongoing psychological trauma.[26] Participants described how traumatized they felt after an assault and how little compassion they felt they received.

- There's no follow up with management. They don't ask you if you're okay. They ask, "Can you take Tylenol and stay here?"

After a serious violent physical and sexual assault by a male resident, a participant described what happened when she reported the incident to her supervisor.

- I was walking around the floor shaking. I was a zombie. I went back to my supervisor and said I needed to go home. She was shocked and said, "Did something else happen that I'm not aware of?" And I said, "No I think I told you everything." "Well are you hurt? Do you need to go to the hospital?" "No. I'm not really physically hurt. I'm just not thinking right." She still wanted me to stay so they wouldn't be short staffed. I did finally go home but all I could think about was that I was a feather stroke away from being raped. I went back to work on my next scheduled shift and every time a male resident moved too quickly towards me it was too much for me to handle. I decided I needed some time off work to emotionally heal.

Although the incident being described had taken place several months prior to the interview, the participant broke down in tears telling her story. Several other participants, some of whom had themselves been sexually assaulted by residents, were deeply emotionally affected, and they also shed tears as they offered the storyteller their support and compassion.

In addition to the lack of immediate or ongoing psychological supports from management, there were criticisms of the workers' compensation system that failed to recognize their injuries or delayed accepting claims and making payments.

- I went through ten different compensation case managers. Every time I would try to get a hold of them, they would put me through to somebody else. It took me four months to be paid. And mine was a clear-cut case.
- If you are suffering from PTSD, they ask, "Were you abused as a child? Did you come from a divorced family? Could any of these things have been a precursor to your problem and not really the assault that happened at work?" You're put through all this testing and emotional crap and you're already traumatized.

Participants talked about how the combination of violence, fear, stress, workload, disrespect, lack of compassionate support, as well as feeling professionally inadequate due to time constraints leads to physical and emotional exhaustion.

- We are not happy because we're burnt out. We feel helpless and hopeless because we can't protect ourselves and we can't protect the residents. I'm supposed to be caring for these people. There's just not enough staff. Of course, you take it home with you.
- When I go home and I'm trying to sleep at night I can still hear the poor man screaming. I'm not able to let that go. Or that poor woman lying in her bed that I didn't have time to tend to. That bothers me even more.
- They're not machinery. We're not dealing with car parts. We're dealing with actual human beings that you can't rush and that deserve better than what we're giving them. At the end of my shift I feel exhausted, mentally and physically.
- Not only are we subject to abuse, we are working short because people are exhausted, people are tired so they're calling in sick. I'm so exhausted, sometimes I cry on the way home.
- If a resident has died overnight, I don't want to think that yesterday he was cold, and I didn't have time to get the sweater he asked for on the last day of his life.
- It just sucks the life out of you. You think, "I'll go in and I try to do the best I can." And you come out and you feel so defeated. We have the most thankless job there is.

Residents' rights and the control held by family members lead to conflict and sometimes abuse of staff. Overworked staff who cannot keep up with resident care can be verbally abused by family members who are not satisfied with the care being provided.

- When we're short, we're getting blamed if Dad hasn't had a bath or is soiled. We're the first ones they target. And we're not allowed to say, "I'm sorry, we're short staffed today."

Risk Factors

A wide range of risk factors for Type II violence emerged during the discussion. Key among them—and widely agreed upon—were the increased acuity of residents, understaffing, lack of security measures, a task-oriented organization of work that provides too little time not only for basic care but for resident-centered relational care, the physical environment, and inadequate training.

Resident Acuity

The acuity of LTC residents, which includes adults of all ages, is very high and is contributing to the risk of violence.

- Residents are coming in sicker and with more dementia, and they have more responsive behaviors like kicking, spitting, and scratching.
- When I was first hired, you had to be ambulatory to get into the building. Now they're on a stretcher. There are feeding tubes. There's oxygen.
- One of my residents is this homeless guy that was a drug addict. He's a real handful to look after and he's younger than me. We had a lady in her twenties with brain damage from an accident and she shared a room with a woman who was 102. They're all mixed in together.
- Now people are coming in who are thirty, forty, fifty. The last several people that have been admitted are in their fifties and have mental health diagnoses. Long-term care is not equipped to deal with people who have mental health issues. We don't have outside support. We don't have a psychiatrist or a psychologist like they do in a hospital.
- We have a resident who is an ex-fighter. He's hit a few people in the face. He was mumbling something, and I said, "Pardon me," and he went pop with his fist, right in the face.

Understaffing

While the acuity of residents has increased, staffing levels have remained constant for the last five years.[27] Government mandated staff-to-resident ratios are difficult to interpret and easy to manipulate. An independent report on LTC staffing levels in Ontario published a decade ago revealed that understaffing seriously affects quality of care. It recommended that staffing levels of all direct care staff be increased according to the particular character and needs of the resident population. The report also called for at least four hours of hands-on care per day per resident.[28] This need remains unmet today, although

legislation, called the *Time to Care Act*, has been introduced in Ontario requiring the four-hour minimum standard.[29,30] In the participants' experience, the residents continue to receive far less. They estimate, for example, that they are able to spend only a few minutes per resident during the morning routine.

- Do the math. On Sunday, I had ten residents to care for. Three of them were showers. I start at 6:30 and breakfast is at 8:00. So, I have ninety minutes.
- What we're supposed to do is washing of the armpits, face, and hands and doing mouth care and peri care, getting them dressed. What actually happens is peri care—sometimes they get their teeth done. They might be able to have a glass of water or a drink before they get shipped to the dining room. It's like an assembly line. Then we take them down, we serve breakfast, we need to feed them, we need to clean up. And then after breakfast, we take them back down to their room if that's where they want to sit.
- You just say, "Good morning" and "I'm here to get you up for breakfast. I'll be right back." And then you run back, and you wash their face, their hands, their underarms, under their breasts while they're in the bed. And then you roll them, as you're putting on their incontinence product, pull their pants up, and then they'll either get up on their own or you put the bed up, turn them, get them sitting. Then you have to take care of all the dirty linens, put all their washing material back in the closet, and wipe it all down.
- I think it has to be the worst thing when you're in there and the call bells are ringing and this one over here is screaming and that one is yelling, and you're always thinking, "Oh my god. No break today." I've still got three cares to do, breakfast is in twenty minutes and I've got to have them all in the dining room.
- I work on a unit with twenty-five to one. My partner, the other PSW that I call on if I need help with a two-person, she has thirty-seven to one, and these are not independent people. I have, in my unit alone, nine residents who require two people for their bed mobility, or to do their care. So how do you manage that? You have to be constantly robbing from Peter to pay Paul.

Understaffing has been identified as a contributor to violence against staff in LTC. "One-to-one attention and care that comes from having more staff can alleviate some of the triggers that influence aggressive behaviors."[27] Working short-staffed or alone carries additional risks.

- You have three staff to sixty residents on a nightshift. It's not safe for residents nor the staff involved.
- I had a coworker on night shift who was being strangled. She was by herself. She couldn't get to her whistle. A resident who was coherent enough actually saved her.

Organization of Work

The organization of work and work practices are determined by administrative decisions aimed at efficiency and productivity. Care is broken down into specific tasks: bathing, dressing, toileting, and feeding. Time management, budgetary interests, and management efficiency practices in today's healthcare system seem to supersede the principle of patient- or resident-centered care as the concept of "Medical Taylorism" becomes the dominant driving principle.[31] In the context of LTC, this tendency toward "industrialization"[32] means that practical tasks are the priority, and less time is allocated to relational care that involves a broader range of care services and meaningful two-way social interactions between residents and staff. Numerous studies have identified that strict hierarchical staff structures and the accompanying rigid assigned tasks allow for limited caregiver flexibility to address residents' needs.[33,34] This has a direct impact on residents' quality of life and may contribute to their agitation, fear, or confusion, which can then lead to aggression.

- We are now so task-oriented.
- And of course, the residents are agitated because there's no time to spend with them anymore. If you spend five or six minutes with each one of them, even during suppertime, it's a bonus.
- We would all love to do the kind of care that we would expect for ourselves—the calm, quiet, slow moving care. A little chat in the morning. What you'd expect, especially if you are in your eighties and are really severely dependent on a care worker. But that is not the reality.
- We used to be able to develop a relationship. We could talk. They took that out of our care. Now all we do is basically factory work. It's like putting 100-pound bags of potatoes into bed. Good night. That's it. That's health care. Now it's an assembly line.

When staff is too busy to relate at more than a superficial level with residents, the opportunity to alleviate their psychological suffering is also lost, leading to the potential for more aggression.

- We had a resident who was physically okay, but he had serious PTSD. In the middle of the night, he would have nightmares and he would need staff to sit with him.
- You see them getting more depressed and not thriving. Sometimes they just need a hug or just holding their hand walking down the hall chatting away. Well you try to do it in between your tasks. You're multi-tasking all the time. Even though you're trying to hurry down the hall to another one because they're ringing, you're holding hands and you're trying to make sure that this one is feeling comfortable because you know this one's going to act out if you don't.

- I feel like I have to make these decisions almost every shift. Like, "Hmm, which one comes first?" And I don't really think that's fair. I always consider these three things: Are they safe? Are they happy? Are they comfortable? And I feel like I can manage one out of three at best.

Residents can sense their caregivers' stress and may mirror their state of mind. This can then lead to "responsive behaviors," like lashing out.

- Do our actions perhaps cause them to act aggressively towards us? I would say so.
- Especially with our dementia patients. They need time to process. You can't rush them. You have to wait for them and if you try to hurry them, they react.
- They're mad. They're agitated because we're agitated. They want to go to bed yet they're sitting there for a whole hour waiting and then when I come into the room, they're mad at me. So I'm the first one that's going to get kicked, punched, or spit at or called "you stupid bitch."

The hierarchy among LTC personnel can lead to conditions that can increase the chances of violent behaviors. For example, physicians often do not communicate well with the PSWs and RPNs who are closest to the residents. As a result, medications may be prescribed or withdrawn without consideration of the consequences.

There is ongoing controversy over the issue of medicating residents. In recent years, the use of antipsychotic drugs has been reduced by more than a third.[14] Participants agree that chemical restraints should not be overly prescribed. However, there has been no corresponding increase in staffing and other resources to deal with resulting increases in resident agitation.

- The doctor will come in and look at a resident. We're pulling our hair out saying, "Listen, something has to change here" and the doctor says, "I find her very endearing." So, the problem remains.
- The doctor takes away their medication. If I say, "This person is escalating. He's going to start striking." They say, "No, he's not that bad."

One of the strategies that was introduced in 2010 is BSO. Their function is to assess behavioral issues among residents with cognitive or neurological deficits and establish care plans.[27] However, not all facilities have in-house teams. Furthermore, as is the case with the reduction in use of medications, additional staffing is required to carry out the BSO plans.

- Behavioral support are there weekly but don't add care staff. They're there to assist in advising on whether there's a change of medications to give,

recommendations to the physicians, but they're not there to put time in with residents.
- You have fifteen care plans which you're supposed to know inside out and then the BSO gets involved and creates another ten strategies which adds another five pages to the care plan. Where's the staff to implement those strategies?

Lack of Security Measures

Security personnel are generally not available or trained to handle aggressive residents, leaving the care staff to handle their own emergencies, such as *Code White* calls indicating violence is being threatened or is underway.

- Security staff don't interfere in Code Whites. They just direct the police officer to the floor if they are called. I don't think they have any special training in any type of de-escalation. They wouldn't know how to help you.

Physical Environment

Participants were critical of aspects of the physical work environment including building design features that left them with no egress when confronted by an attacker, poor communication capabilities, and inadequate security measures.

- You can't even hear our overhead speakers when you're in a resident's room. Because you have to shut the door for privacy.
- There's a big section between the two hallways. I'm down in one. How is my coworker going to hear me while she's giving a bath? And 90 percent of the time, I'm working short. So, who's going to come and help me?

Each facility has its own method whereby staff communicate that they need help. Some have walkie talkies or whistles. Others have no mechanical means to call for help.

- There are policies in some care homes against using your own cellphones. Which is fair enough. But they should have personal alarms on all the PSWs and registered staff because they're in rooms alone with people.
- He had me backed up in the corner, punching me, and I was blowing the whistle over and over and it was in his face and it didn't even have any reaction. He was still pounding away, nobody heard the whistle. He just happened to back up a little bit and I was able to get out—but it was scary.
- A PSW was down in a room and she was very pregnant doing a one-on-one with this aggressive guy. It took a long time before somebody heard her and pulled him off. She was hurt.

- I've been in a situation where I've been at the end of the hall with a violent resident and he had me up against the wall and I was yelling. And no one could hear me. I finally managed to get my own cell phone out of my pocket and I called the RN.
- I can't breathe because I'm getting choked so a whistle's useless to me.

Resident agitation can be exacerbated by their immediate environment which can then lead to outbursts directed against their caregivers. A review of the impact of building design and the physical environment on residents with dementia, which make up the majority of the LTC population, found that, "There is substantial evidence on the influence of unit size, spatial layout, home-like character, sensory stimulation, and environmental characteristics of social spaces on residents' behaviors and well-being in care facilities."[35]

Residents in many LTC homes are housed in double rooms, contributing to a lack of privacy as well as increasing their exposure to irritating disturbances, lights, and noise.

- Listening to all the sounds, noise, smells, having staff in and out of your room non-stop throughout the day. That commotion contributes to agitation.
- So many times, we've had people saying, "Oh, I'm scared of the dark, I want to sleep with my light on." Okay, that's totally fine, if that's what you prefer to be comfortable and content, but your roommate wants the light off. You like to fall asleep with TV on, but you can't. Even language differences among roommates can be a problem.
- Sometimes there are people that holler all night. So, you can imagine if your roommate is hollering twenty-four hours a day. It can really irritate you. You can't sleep and you're not well. The problem is that there's no place else to put that hollering person.

Perhaps one of the most troubling practices is that of separating couples when facilities can't readily accommodate them together.

> I see an increase in behaviors—especially from married couples that want to see each other. They were married for sixty-eight years and always had the same bed, and then they move in and are not allowed to be in the same room anymore. Some of them have been living in the home for three or four years and they're not able to live together. We classify certain rooms by gender, so if a room is classified as a male only room, no females are to be in that room. Or they'll throw one on the third floor and keep one down on the main floor, and if we have time as caregivers, we'll try to bring them together to see each other once a week.

Studies have found that residents with dementia benefit from taking part in simple outdoor activities, which convey "a positive impact on mental health,

quality of life and mood, as well as reduced agitation, aggression and reduced use of behavioral medication."[35] According to the study participants, most residents are never able to go outside unless they have a family member or private caregiver who will take them. Music, dancing, and other activities have also been shown to reduce aggression in some residents with dementia.[36,37]

> We notice also when there's a music group that comes to the unit, there's less stress. It's calmer. There are fewer people walking around. And we can do our jobs better.

Unfortunately, often recreational or entertainment programs are unavailable—either because of scheduling or illness outbreaks.

- There's usually nothing scheduled on the weekends. And usually every night around seven o'clock all programming comes to a halt. They need something in the evening. There's too much time on their hands. They get bored and they get angry and that's when it gets worse. That's also when the staff levels go down.
- When we're on outbreak, all activities get cancelled for the duration of the outbreak, so that could be for three weeks, it could be for three months. And that makes them go stark crazy. And they can't leave their units either. And we're on outbreak a lot. In a bad year, we can be on outbreak a total of six months.

Inadequate Training

The principle caregivers, the PSWs and RPNs, who come into regular direct contact with volatile residents, do not feel adequately prepared to deal with aggression.

> We are not psychiatric nurses. We don't have the training to work in a psychiatric hospital. I'm touching these people and caring for them on a daily basis and I have no training whatsoever how to protect myself.

Solutions

The participants offered primary and secondary prevention ideas for addressing immediate and underlying causes of violence. These coincided with ideas for improving the quality of care for residents while at the same time improving their own work lives. Some solutions were practical while others called for broad institutional and systemic change. They are listed as follows, in the participants' own words:

- More staff. You need to be regularly working in pairs. Safety in numbers.

- If you could call three staff to come into the room, you wouldn't be so stressed out and you'd be protected from an aggressive resident. If you had one that could hold their hands down and then two that do the care. You could talk to them and tell them your life story and distract them while the other two are doing care. Never do we have three staff.
- We need a flagging system to warn us about residents who have a history of violence. We used to flag the door, but they stopped it for privacy reasons.
- We need better training. Most hospital settings have Crisis Intervention Training, which is more in-depth. It's more hands-on. It teaches you valuable skills and it would be an ideal thing for a LTC facility. The keyword is Intervention—it actually teaches you how to stop it.
- People are saying "You need more training." No, we need staff. We need money, we need legislation to help fix this. It's not happening.
- The biggest thing, I think, is that we need to start to help develop therapeutic professional relationships with the residents. And part of that would be understanding that we're limited in terms of the staffing levels that we do have, that we don't have the time to do that.
- We can't be putting the old and frail with the young and mentally disturbed.
- We need more family involvement. And when residents are admitted, families should sign a code of conduct acknowledging how and how not to treat staff.
- They have to hire more BSO nurses. Can you imagine 400 beds and only one BSO?
- We don't have enough male PSWs. I think that male PSWs should be looking after male residents as opposed to women doing it. And they might not be whacking at them as often as they whack at women.
- We also need a safe room where residents who are agitated can go to calm down.
- I would like to see a more homelike setting. I think we need to make it more resident focused. We're just taking them and saying this is your home and you're expecting them to adapt.
- Part of the training for PSWs should include the importance of knowing what to do when there's violence in the workplace and the importance of reporting. They really need to know what the reality is because they are not prepared when they come in and they see a resident calling you names and spitting and throwing stuff at you.
- We have to report incidents—report, report, report—because it is not right to be getting spit at or hit in your job.

Interestingly, many of the primary and secondary prevention ideas put forward by the participants mirrored those suggested by the Ontario Long Term Care Association[27] namely: increased funding, increased staffing, more one-to-one care, redesigned buildings, and in-house BSO teams.

They also suggested tertiary prevention strategies to mitigate psychological trauma they experience after being abused or assaulted and for the burnout they experience from being overworked and feeling undervalued. They feel they are expected to tolerate the risk of violence and abuse and to accept it as simply "part of the job."

> I asked to be excused from caring for someone who was punching me on a daily basis and causing bruising. My supervisor actually said to me, "This is part of your job."

They said they needed more support from management, particularly after a violent incident. One of the participants emphasized the need for management to be trained in "compassion." They talked about the need for the workers' compensation system to recognize PTSD in LTC workers. They said they were often not granted adequate time off to recover from an assault. They believe they deserve more respect from cognitive residents, family members, supervisory medical personnel, and doctors. They want zero tolerance policies for violence against them to be established and enforced.

Barriers to Prevention

While there is ample literature describing the problem of violence against staff in LTC, many of which offer practical, achievable solutions, it remains largely unaddressed. The barriers to prevention are complex. One of the more insidious is the lack of public awareness of its severity and ubiquity. Public demand and lobbying for change depend on awareness. Unfortunately, the workers at risk, those who are most cognizant of the failings of the system, do not feel they can safely talk about it.

- We're not allowed to talk about what happens in our workplace because it could cost us our employment.
- I think it would make a difference if it was out in the public. I think I should be able to stand up there and tell the stories that have to be told because a lot of people don't realize what's happening. And I think that's tragic.
- I wish the public were better educated as to what really happens in a long-term care facility. The public needs to know the reality—our reality. You know what? They really only get a bath once every two or three weeks. I know some that just got a bed bath for eight or nine weeks. But you can't tell the family.
- If a policeman gets punched in the face, it's on video all over the place. I would be fired. Because it would be seen as a breach of confidentiality.

Without public awareness and support, individual LTC staff do not feel they are in a strong enough position to advocate for change. Unlike nurses, PSWs in Ontario do not have a regulatory college to provide protection, direction, and professional recognition.

Rather than individually or collectively challenging their employers to provide more protections, many participants turn to their own personal coping strategies. Some expressed a sense of defeatism.

> I have to numb myself to it all. If I thought about it all the time, I'd probably have constant migraines—because there's nothing I can do.

Some counted the months and years before they could retire. Some switched occupations in order to avoid direct resident contact.

> I've been in nursing for over thirty years, but I decided to switch to housekeeping because I couldn't take it any longer.

Despite the danger to themselves, staff tend not to blame residents who are not in control of their actions and viewed aggression from those with dementia with some sympathy or detachment.

> At first it broke my heart. Now I'm used to it. I know that because they're sick or they have dementia, they probably don't even mean it; they don't realize they're angry. They don't know what's going on anymore.

But not everyone was willing to see abuse as inevitable or accept it as intrinsic to the job.

> I think there's a culture that accepts aggression from residents. Since they don't mean it, it's not the same. They don't know what they're doing when they spit on you. Well, I believe I still have the right to be at work and not get spit on, even though that person has dementia. Those things shouldn't become a normal part of your job.

Statistics regarding the actual incidence of violence are not available because most incidents are not reported,[6] making it even more difficult to make the case for prevention.

- I look at my coworkers who work on the locked unit. Their arms are literally covered in bruises. I was really upset and asked if they were reporting the incidents that caused the bruises. They said, "We didn't know we were supposed to."
- People stop reporting because it happens every day. "Oh, they always do that. They always pinch me. They always grab my breast when I'm doing care on them or they grab my crotch."

One of the deterrents to reporting incidents of violence is fear of being blamed.

- If you do report, the first thing they ask is "How did you trigger the resident? Did you provoke it? What did you do to make this happen? What was your approach? Don't you think that they perceived you as aggressive, rushing in?" But I've only got two minutes to get the person up.
- I've tried hundreds of approaches and it doesn't matter because this lady has dementia and whatever's happening in her mind is what's causing her to be violent. And I have no control over what's happening in her mind.
- They don't really give you a lot of support. They may look like they're trying but basically the blame still falls on you. "Why didn't you speak more softly? Why didn't you approach with more caution?" But in the moment, you don't see those things. All you're trying to do is get away from what's coming at you.
- A lot of us don't report because we don't want a bullseye on us. We feel if we keep reporting we're going to get written up.

There is also a lack of protective legislation and enforcement, again likely in part due to under-reporting and a resulting lack of statistical data.

Underfunding was universally cited as a significant barrier to preventing aggression against caregivers. Increased funds are key to enhancing staffing levels to better perform both basic and relational care, providing safe and resident-friendly facilities, increasing programs such as music, recreation, and outdoor time—all of which can improve residents' quality of life and in turn reduce agitation. It would also make it possible for all LTC homes to have their own in-house BSO teams.

> We ask management for better education and something to help us deal with residents who are being aggressive. Their response is, "Where are we going to get the money for that?"

Management's attitude toward staff's concerns about violence is reflective of the budgetary constraints they are working under. The prioritizing of efficiency and task completion leaves little room for addressing residents' frame of mind or staff's ability to provide the degree of compassionate care that residents need for their human dignity and to keep them from lashing out in frustration, anger, fear, or confusion.

Discussion

As researchers, we were affected by the heartfelt responses of the participants to our questions. It was evident how emotionally difficult it was for some of them to respond as they described in disturbing detail, attacks on themselves and

coworkers. They talked with palpable pain and resentment about the sexual humiliation they experience. They anguished over the plight of the residents they feel unable to properly care for. Their sense of frustration and demoralization was apparent when asked to talk about what needs to be done to bring about improvements.

This study is both enlightening and disturbing. It sheds light on an aspect of LTC that the public seldom considers—the day-to-day experiences of LTC staff. As a qualitative descriptive exploration, it pulls together insights from the perspectives of those most at risk—the caregivers themselves. It is somewhat limited in that it does not include participants from small remote communities where conditions may differ from those in larger metropolitan areas. Its findings, however, are consistent with the robust literature establishing that violence against caregivers is widespread and uncontrolled. There are many reasons why the problem remains unaddressed. The organization of work in LTC is highly regimented, task-oriented, and focused on management-driven efficiency. It minimizes the opportunity for resident-centered relational care. As a result, there are consequences for the quality of care, job satisfaction, and levels of work-related stress and burnout as well as a heightening of resident–against-staff violence.[8,38–40]

Staff and residents in understaffed LTC homes are essentially locked together in a mutually degrading environment. According to the participants, staff morale is very low. They also experience the people they care for as being very unhappy. Both can be seen as victims of an economic system that devalues caregivers and persons needing care. The caregivers, most of whom are women and many of whom are immigrant and racialized, are viewed as doing menial work. The residents are no longer considered to be of productive value to a society that sees them primarily as a financial drain. Imagine an industrial work force that is subjected to dangerous equipment every day without any machine guarding, lock-out controls, or personal protective equipment. Because in LTC, the hazard arises from dependent people, there does not seem to be the same consideration paid to the safety of those working in harm's way.

The staff is also treading an emotionally challenging path. As the term *caregiver* suggests, their role is to care—physically and emotionally—for those in their charge. Unfortunately, they are inadequately equipped, due to budgetary constraints and other factors, to satisfactorily carry out their mandate. Yet they are being emotionally exploited to do the best they can anyway and to turn the other cheek to the insults and assaults hurled their way. They are expected to be caring and compassionate in their work no matter the dangers, but they themselves seem not to be entitled to care and compassion from their employers. On the contrary, they feel instead they are being blamed when they are assaulted. This sounds uncomfortably like the way women have been made to

feel by society when they have been victimized by violence—an injustice that is now being widely challenged. As Banerjee et al. have stated:

> The failure to adequately address ongoing risk, the normalization of violence and the blaming of victims is characteristic of violence against women. We therefore question why gender has typically been absent in analyses of health-sector violence.[6]

We have to decide whether we really care about our dependent population—the aged and mentally challenged members of our society. If so, additional financial support must be provided by the government and upgraded minimum regulatory standards for care must be instituted. In order for it to happen, caregivers need to be protected and respected and allowed to speak about what they believe is needed.

It will take more than a few small reforms to protect LTC staff from violence in a frayed system that appears to be at its breaking point. Based on the findings of this study and the existing research supporting these results, the authors recommend that comprehensive violence prevention programs be mandated by provincial governments. They should include the solutions put forward by the participants, like the call for personal alarms and the identification of violent residents. The authors further recommend that whistle-blower protections for long-term care staff who speak out about the problem of violence be legislated. They also encourage the enactment of legislation like the proposed *Time to Care Act* amending existing Ontario LTC legislation, which would provide for a minimum of four hours of daily care along with more humane resident-centered care.

We also need to look to the strategies employed in other countries for solutions. Studies comparing violence against LTC care staff in Canada and Scandinavia demonstrate the importance of prioritizing LTC as part of government's responsibility toward overall "social care."[6] This principle is apparent in the higher staffing levels and approach to care provided in Scandinavian countries. For example, each caregiver is more likely to provide a broader range of services, such as medical and personal care as well as cleaning and other tasks, resulting in more of the psychologically important relational care.

This approach contrasts with the neoliberal policies increasingly being adopted by Canadian provincial governments. As economic priorities in Canada and most other capitalist nations shift increasingly to maximizing wealth accumulation by a small proportion of the populations, austerity-driven cuts to government funding for public health services have reduced access to care, forced lowered staffing levels, prioritized efficiencies over relational care, and eliminated specialized programs and services. Increased workloads and staff responsibilities are eroding the quality of resident care. As a result, staff members face an escalating risk of violence from frustrated or

inadequately cared for residents. They also suffer from stress, anxiety, and demoralization.

Unless the issue of understaffing is addressed, the problem of pervasive violence against LTC staff will persist and, given the increasing acuity of the resident population, lack of government regulation, and under-resourcing, it is likely to intensify.

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