Voices:

Hospital workers talk about violence in the workplace

OCHU

ONTARIO COUNCIL OF HOSPITAL UNIONS

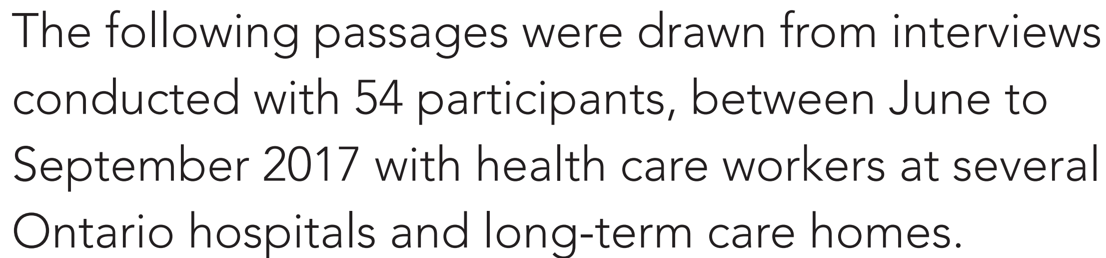
CUPE

What exactly is workplace violence?

According to the Canadian Centre for Occupational Health and Safety: It is any act in which a person is abused, threatened, intimidated or assaulted in his or her employment.

Workplace violence includes:

- **Threatening behaviour** - such as shaking fists, destroying property or throwing objects.
- **Verbal or written threats** - any expression of an intent to inflict harm.
- **Harassment** - any behaviour that demeans, embarrasses, humiliates, annoys, alarms or verbally abuses a person and that is known or would be expected to be unwelcome. This includes words, gestures, intimidation, bullying, or other inappropriate activities.
- **Verbal abuse** - swearing, insults or condescending language.
- **Physical attacks** - hitting, shoving, pushing or kicking.
- **Sexual violence** - physical or psychological violence, carried out through sexual means or by targeting sexuality, including (but not limited to) sexual assault and abuse, rape, sexual and cyber harassment and stalking.



The following passages were drawn from interviews conducted with 54 participants, between June to September 2017 with health care workers at several Ontario hospitals and long-term care homes.

They have been edited for clarity and to protect the identity of those who have courageously agreed to share their experiences.

Their voices are interspersed.

Enough is enough

"I could be dead and I wouldn't see my children"

He just lost it.

There were two of us in the area at the time. It was hard to keep him calm, even with [de-escalation techniques]. He started knocking over the furniture. I remember I had a hold of him at one time – and I remember him throwing furniture. Other patients wanted to help but I said, "Just leave us alone."

And then some other staff came in. We got him to the ground but only after my co-worker almost went through the glass window. He got cut up pretty bad and he was full of blood and we were still dealing with this patient. And then the patient had a hold of my right hand and I was down and he flipped me over right on top of him. I ended up on the other side of him and he still had a hold of my wrist.

The staff called a Code White but the team couldn't get on the unit. The doors had malfunctioned. Alarms were malfunctioning. They weren't working. Even the managers couldn't get in. Nobody had a key that could work. So it was just us – the staff on the floor trying to contain the other patients and the patient who was acting out. And I remember all through it I had blood all over me and I wasn't even sure who it was from. Was it me? Was it a patient? Somebody was hurt! . . .

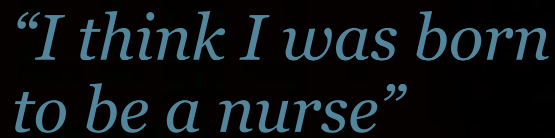
. . . And he had a hold of my wrist SO hard. He had it wrapped around a chair and he was trying to throw the chair. One of the staff finally got my hand free. But the patient was very strong. And I remember the other person with me was covered in blood. It was just wild – something I've just never experienced, and I've been there a long time.

And the panic you feel – with not being able to control somebody. We had to wait for other people, and people were still getting hurt. He was really psychotic and we just couldn't get control of him. And I don't know how long it went on. It just seemed like forever. And I don't remember anything past the point where they put the patient in seclusion. I don't know where I was or what I was doing. And even when they put him in seclusion – I don't remember if I was a part of it or not – I just remember smelling blood everywhere. I had it on my hands . . . and I had it here . . . and up on my top . . . and on my pants . . . everywhere.

There was so much blood. It turned out to have been from my co-worker. I actually thought he might have such a bad concussion that something might happen to him. Because he had a cut here, and down here, and his whole face was purple. And they couldn't even get him to an ambulance because nobody could get through the doors! The doors were all got locked and they couldn't be opened. And to see a co-worker get beaten up like that! I can still remember the top that I had on – it was a white top – and I remember when everybody did manage to get on the floor, they said,

"Oh my god, you're full of blood!"
But it wasn't me – and I told them.

Some of the nurses helped me take my clothes off anyway and they checked me to make sure it wasn't me. And I was just in shock – I couldn't believe what had just happened. And then when we all got him into seclusion, the management came through. They were supportive. They knew what we had been through. But to this day, when I go to that floor, I get so upset, I don't want to be there. But I realize it wasn't the patient; it was the actual incident that had that such a traumatic effect on me . . . the fear of being in something like that. You never know if you're going to come out alive! Later on my co-worker and I talked about it. And he said, "Thank god it was you with me, and not somebody else. I could be dead and I wouldn't see my children again." That really did bother me.



Nursing can bring tremendous rewards. Given adequate opportunities, time, and resources nurses can derive immense satisfaction from helping patients get well, to provide care and comfort when patients most need it.

- I think I was born to be a nurse. It's something I'v always wanted to do. I've always loved looking after people, making them feel better. I still love what I do but there is something I don't love – and that's dealing with violent situations!
- As a child I really admired what the nurses and doctors did. So I chose to do the same thing because I felt that helping people was a valuable career and I figured nursing was the best way to do that.
- Nursing was always a lifetime goal that I wanted to achieve – to help others through whatever circumstances or health conditions they have.
- I've always been good at caring for other people. It's just something I have a knack for – getting someone coffee. Or palliative patients – just painting their nails – something small. If it brightens their day, makes their day better, it's a very rewarding career. I knew it would be, but I didn't know I would get as much joy out of it as I do. I love being a nurse.
- Early in my career, I saw vulnerable people with mental health issues. I saw that with proper intervention, education, support, therapy – they got better. And they were just – you know – normal, nice people. And I found that so rewarding. And it would sometimes take six months to a year for people to recover. And it's a long journey – for you and for them. To get them well again. But to see them go out that door and be well? It's just the most rewarding experience ever.
- And as a nurse, you're expected to care for that patient as if they were your own flesh and blood. That's how I see it. I give 150 percent every time I come in. I give all I can to my patients, because during that time frame when they are without their family – they're my family. I'm the one caring for them. I'm the one who's supposed to advocate for them, protect them, get them everything they need, make sure they're safe. For the entire time I'm with them, I'm accountable for them. Every nurse is.

WHAT'S CHANGED IN HEALTH CARE?

- The difficult part is when you don't meet those needs, even if you're giving 150 percent, you're giving every little ounce you can – you've missed your break – you haven't gone to the washroom in four hours – but then you didn't heat up a coffee or get them a warm blanket and that's the end of the world. And that's the reason they're cussing you out when you tried so hard to keep them happy.
- I work mostly with seniors. Dementia care. I really enjoy it. But I've noticed a change in the past few years – mainly the past five years. We don't have as much time to care for them. So it's a little more mentally stressful. Due to the fact that we had a lot more time when I first was a nurse – to care and spend time with them. And you see their behaviours change due to the fact that we don't get to spend time with them at all any more. I'd say at least fifty percent of the time has been decreased, and it's frustrating for us. Because it's mostly paperwork and other things, and meetings. There's not enough staff.

"Part of the job"

The experience of nurses in some of today's violence riddled institutions is a far cry from what they imagined as new graduates. Somehow violence has become normalized, particularly in such volatile settings as psychiatric and forensics units, emergency departments, and some long-term care facilities. But every unit in every health care institution carries the potential for violence.

- You don't expect, going to work, that you're going to get hurt – that you're going to be in that situation. Whether you're on a behavioral unit, whether you're on a medically complex unit, whether you're on the ICU – you don't expect to come in to work and get hurt. But it does happen. It's unfortunate, but it does happen. And it's under-reported, because we chalk it up as just something that's part of the job.
- I've been spit on twice in the eye. I hurt my arm really badly because a client [with dementia] was pulling on it really aggressively one time. He was a strong man and I was alone. By the time another staff ran out it was too late, because I was already hurt. I was bitten just a few years ago – I had to go to the hospital to get a tetanus shot.

They put steri-strips on to heal it and I have a scar. And I have a scar across my chest from being scratched by bending down and helping a lady out of a chair. She was just sitting there, one of us on each side. We went to help her up. She was very calm and all of a sudden she scratched me. Tried to scratch my co-worker, but I wasn't as quick to move. I've been kicked in my privates – not very long ago. That one hurt. I've been punched many times. My arm really hurts to this day, and my wrist. I've been grabbed.

When you hold hands sometimes, when a client is walking down the hall, they'll become aggressive and they'll just squish your hand so hard. And it's hard to get out of that. So my arm hurts, my wrist, my thumb. There have been many other incidents. Lots of close calls as well. We learn to move quickly. If I didn't learn the moves I probably would have been injured more. The faster you are, the safer you are!

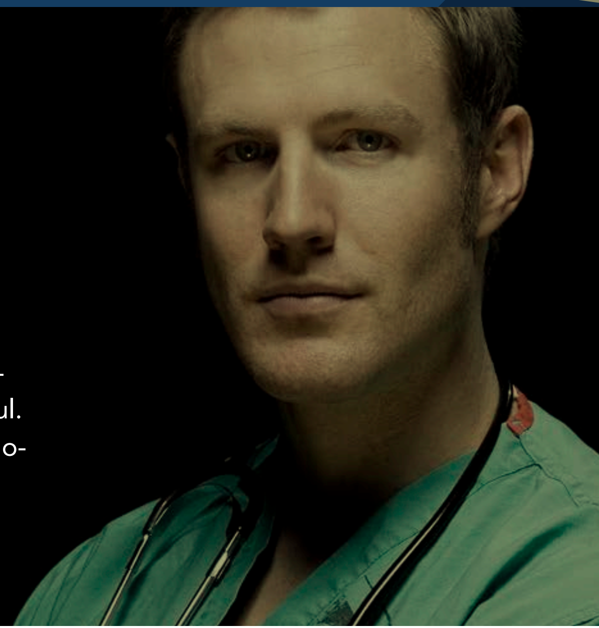
- I've heard new staff that have just graduated out of the college say, **"They told us in school that it's just part of the job – it's to be accepted." And I think that's such a shame**, that we've got these young registered practical nurses – RPNs – coming out of college and they are teaching them – putting this disgusting thought in their heads – that this is expected to be part of your job – to be hit, assaulted, bit, sworn at, threatened. I truly think they need to change the curriculum.
- We've been kicked, scratched, pushed, and bitten when we're secluding people. Because that's our job – to physically take people and put them in seclusion rooms. And we get assaulted while that's happening. And that's simply part of the job. That's what's expected – hands on, physical encounters all the time as part of the job – and nobody seems to question it. It shouldn't be part of the job. Somewhere along the way it has got lost in translation.
- I find that patients that are delusional, or they have dementia, have struck out, or hit, or bit, or spit – or spit medications at me. They've done those things because they're confused. It doesn't mean it's okay that it happened to me. But you're kind of expected to just deal with it. I find that the physical issues – like physical violence – are more from confused patients. And again, we're kind of under the impression that it's just to be expected on the job.

- I see violence on a daily basis, to be honest. I've seen it many times over the years, but with the seniors especially. Lots of violence. It's mostly due to their cognitive behaviour because they have dementia and they don't know where they are. They'll react very briskly with us. And when we're understaffed, or we're under stress, they sense that right away. And yes, they are very physically aggressive to us. And it's hard. We have staff to support us sometimes. But sometimes you don't. And we're taking a risk at times because it's unpredictable behaviour. There are good times, but they can change on a dime. So you're at risk. They can be aggressive with themselves, with their furniture, with us, with another client – you do see it.

- Patients are brought in with sociopathic behaviours – you wouldn't even know they're mentally ill. They have a security guard on them every shift. So where's the therapeutic rapport? How about a care plan? A REAL nursing care plan that addresses the risks, and how we approach them – so we're all doing the same thing. Wouldn't that reduce violence?
- You know, I don't want to paint mental health clients as all being violent – certainly they are not. But we know that people with mental illness have that potential. And there are other factors – like substance use – that can escalate aggression.
- And then there are patients that are chronic drug users. That wake up and wonder, "Where the hell am I?" So we've cleaned them up and they wake up and they have no idea about the system. And those people can be very dangerous. They plan escapes. You have got to be careful because they are all under one roof, right? You could have the sociopaths, the psychopaths, the personality disorders. You can have the developmentally disabled person, the autistic person. You can have the really physically sick person. Elderly. You can have the sixteen year old! And then we've got people that might have been picked up for dangerous driving, or impaired driving and then they wake up.
- Say you're having a manic episode and are bipolar. And maybe you've been off your medications for a while because maybe you didn't have any money – or access to a doctor to renew a prescription. Common problem. You go to the emergency department. And you're asked to wait 4 or 5 hours before you're even assessed by a nurse? And we wonder, "Why is there violence?"
- Nurses are expected to take care of people, regardless of their behavior or how they're treating them.
- I've been kicked, bitten – I was spit on.
- I've had quite a few incidents where I've been swung at, had things thrown at me. I've been pushed and hit.

“I was a target for no other reason than opportunity”

There is a continuum of violence that ranges from insults and threatening gestures to physical and sexual assault. All incidents are hurtful. They are all violations of human dignity. Some are physically and emotionally devastating – destroying careers and personal wellbeing.



- I've experienced folks grabbing hold of me and twisting my body. I've had people pinching me, or twisting my arms or pulling on my fingers. I've also had a patient whipping a towel and hitting me with it.
- I was a target for no other reason than opportunity. He decided he was going to hit somebody and it just happened I was in his line of sight, so I got hit. No other rhyme or reason, just a very sick person who decided he was going to hurt somebody. That's when I got the punch.
- We've even had some that are sexual – where the patient has fondled the staff.
- I've had medication liquids thrown in my face. I've had urinals and bedpans thrown at me. I've been cussed out in the middle of care for not getting someone what they needed in that very minute – because I was dealing with another patient's health crisis.
- A patient threw IV equipment at me. I mean, whipped it pretty hard right at my face.
- I ended up getting a concussion because I was trying to help a staff member who was being attacked and I had my head hit against the wall.
- I've had glasses of water thrown at me. I've had urinals thrown at me. I've been verbally told to get out of the patient's room, using vulgar language. I've been told that I wasn't worth anything. I don't really want to start using the words that were spoken to me. I've been told that I'm stupid and that I'm good for nothing. So that really hurts, because I would not ever think of doing that to someone else.

- A patient threw a piece of metal and hit a staff person in the face. The wound required stitches.
- I turned a patient over in bed and that's when he took his chance. He just punched me!
- A patient was sitting on a mattress. Suddenly he bolted to his feet with his hand and arm cocked, ran across the room and hit me in the nose and under the eye. I immediately fell backwards. I started to bleed, profusely, from my nose. I couldn't breathe. I started to panic. I couldn't see. My co-workers sort of carried me out of the room and put me in a wheelchair. But the patient then continued to assault the staff in there.
- He stood up and I turned around to see if the door was open. Well, the door was closed! So now he's pushing the chair against me, against the door. So I'm behind the door, with the chair against me, and this big 6 foot 3 guy is just pounding me. He pounded me in the head. He pounded me in the shoulder. He pounded me again in the head. And I'm yelling and screaming and yelling and screaming.

  A patient on the other side of the door heard me. So then a Code White was called. And the other patient on the other side of the door was trying to push the door open. And while the other patient was yelling and screaming, my patient – who is hitting me – stopped hitting me and I slowly started pushing the chair against him, so the door could be opened.

  Otherwise, if that patient had knocked me to the floor, they would have had to push my whole body over to get into the room. You're barricaded into the rooms as soon as you walk in! So the door started opening and tons of staff started coming in. They escorted the patient to the seclusion room. Then they brought me into the nursing station – and that's when I just – fell apart. I started shaking and crying . . . I was in shock. Totally in shock.
- Getting spit on – it's just horrible. You know, we talk about things like the transfer of hepatitis. A lot of our patients are intravenous drug users. A lot of them are positive for hepatitis. You know the patients who are HIV positive and you're dealing with bodily fluids. Sometimes there's blood and you know you have to be careful around that. But again, it seems to be an expected part of the job.
- An agitated patient chased me down the hallway. I locked myself in the nursing station. He went to the other door. The other nurse locked himself in the nursing station. The patient was pounding on the glass. Then he went to another family and became very agitated with them, yelling and shouting verbal abuse at them.
- My colleagues and I were dealing with a patient who had become violent and we were attempting to restrain him and I got bitten on the arm. He wouldn't let go. They actually had to pry him off me.
- I had my arm twisted. And after telling the patient, "You're hurting me, you're hurting me," then they let go and then reached up with their other arm to grab my neck. He just rushed at us and started swinging punches. He punched me three times before I did my best to wrangle, to tackle him to the ground with some other staff. During the first few punches, I was just kind of holding him back, telling him not to punch me. Obviously that didn't work. I had a swollen eye. Other nurses got concussions in the melee. Several people got cuts and scratches.

“I’m gonna get you”

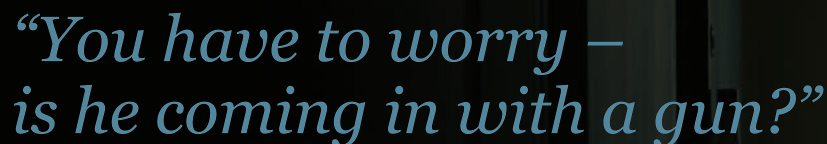
Clear or implied threats of violence can leave health care workers in a state of fear and hyper-vigilance, causing them to look constantly over their shoulders and increasing their stress in an already stressful job.

- I’m verbally assaulted daily in the workplace. I’m physically assaulted – it’s a regular occurrence at work. Mostly what we would consider being a “non-severe” incident – like being scratched or grabbed, or something thrown at you. And then I have been severely injured – where I’ve been punched. I’ve been bitten. I’ve had a concussion.
- I’ve been physically threatened – too numerous to mention. It used to be considered that it comes with the territory when a patient threatens to kill you, or a patient says, “I’m gonna get you, I know your car, I’ll follow you, I know you.” I’ve had more verbal threats than you can imagine.
- A patient became upset and told the nurse that he was going to get the knife – and literally went like THIS – and then said, “I’m going to kill her, and then I’m going to kill myself.”

“I’ve seen awful things”

Witnessing violence is violence in itself and can have lasting effects on health.

- I've seen awful things. I've seen my co-workers, and myself, be ripped apart verbally. I've been called awful, awful, awful names. Over something so small as not getting someone a hot blanket for the bed or the coffee being cold or not getting rid of someone's old water when I brought them new ice water.
- I remember us hearing a co-worker's screams and we ran out into the hall and she was being brutally beaten by a young male, psychotic patient who was high on drugs. If I close my eyes I can still hear him kicking her. And the sound of his boot hitting her. And she was in a fetal position on the floor. When I think back . . . sometimes when I see a movie on TV where there's that kind of violence I have to shut it off, because I think of that incident. For sure it had long-term effects.
- Over the years I've been at several critical incidents. I've seen nurses punched in the face. I've seen nurses thrown against the wall. I've seen nurses have various pieces of furniture thrown at them.
- I've seen lots of people get hurt, get knocked down and slapped, scratched, bitten in seclusion rooms. And some get hurt because the staff is one on top of the other sometimes. So you get sore arms, sore chest. There are lots of people that get hurt throughout the course of Code Whites.
- I've seen chairs throw n at nurses in dining rooms when the patient has escalated – had a psychotic break – and they start throwing furniture at us. I've seen a nurse attacked with a fork.



"You have to worry – is he coming in with a gun?"

Fear of violence taints the work experience, sometimes turning it into a thing to be dreaded – eroding satisfaction and trust.

- I never really know whether I – or my co-workers – will be getting home at night.
- It's unsafe. I go to work every day knowing that I will be abused, either verbally or physically that day. So every day I prepare myself for that. And I shouldn't have to… Nobody should have to go into work knowing that they are going to possibly be assaulted one way or another in the workplace.
- You have to worry – is he coming in with a gun? Or does he have drugs? Or is he strung out? Or is he going to beat somebody up today? Or why is he so moody? Is something wrong with him and he doesn't want to talk to you? It's hard every day to come into work to something like that.
- It changes how you feel about your job. Coming in knowing that you could possibly be hurt is a toxic feeling. It makes you not want to come in.
- The nurses are the ones who have to do that hands-on approach in dealing with a patient who has a weapon – or is swinging at you – or is telling you that if you come near them they will kill you. So it's scary going into those situations because you don't know how it's going to play out. You can plan and plan . . . but it's an unpredictable situation when it comes down to it.

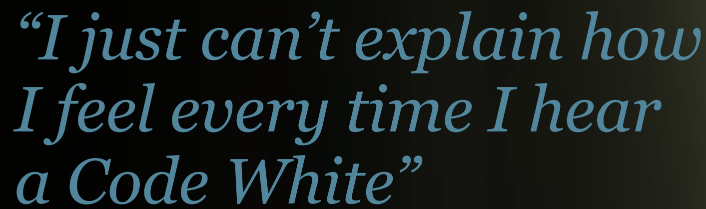
"It's gotten worse"

According to experienced health care workers, violence has not always been the ever-present threat that it is now in many current health care settings.

- In the past few years it seems to be getting a lot worse than I've seen in the past.
- It's getting consistently worse.
- Whether it be verbal abuse, or having something thrown at you, or a towel being hit against your skin.
- I would say that the assaults that have happened recently are much more aggressive, much more dangerous.
- I think the kids are getting sicker. Because I don't think they're getting timely treatment.
- I find that it's becoming more problematic over the years. I'm finding that verbal abuse is on a real rise. Sometimes our patients will start cursing me out, for example, because they don't like the food.

  Or if the patients are angry with their families, I find that they lash out at us. And then the cursing starts, and sometimes the behavior escalates beyond even cursing – it becomes fists.

  And you know, either one is so dangerous to us. And to them too, because you know, patients can get hurt too. Everybody is involved. We need everybody to work together and assist each other so we can find some solutions to these outbursts all the time.



"I just can't explain how I feel every time I hear a Code White"

The announcement of a Code White, which is essentially an urgent appeal for help in controlling a violent incident, can set hearts pounding and palms sweating. Adding to the stress, is the fact that the severity of the incident facing the responders is unknown until they arrive at the scene. And it is not a foolproof system. There is reportedly an inconsistent use of Code Whites. There can be delays and malfunctions. There can be inexperienced responders.

- I just can't explain how I feel every time I hear a Code White. My heart almost goes through my chest. I'm thinking, "Oh my god! Is this going to be a bad one? Or is this going to be a good one?" Every day you think about it. For months I dreamed about the same thing over and over. It's better now, but I still have anxiety around it because this is the type of environment we work in. Right? So it's not going to go away.
- Responding to codes – you get there and you have no idea how you're going to manage this situation. It can be very volatile. You'll get there and it'll be a young, or older strong man – or the responders will be mostly women. And you have to strategize very quickly how you're going to control the situation. And in those cases, you never know whether you're going to be okay or whether your co-workers are going to be okay. And whether you'll be strong enough to take that person down.
- We had a situation where we heard screams. We ran up and saw three staff members who were being brutally punched and kicked and grabbed . . . and they were trying to control the situation. They were trying to subdue the patient. He was threatening to kill them. He was spitting. I pushed my personal alarm to signal a Code White and it failed. The nursing supervisor pushed hers. The people who were involved in handling the assault all pushed theirs . . . and they all failed.

So, the manual code was called. It also failed. For whatever reason the call didn't go through the switchboard. So it was quite a length of time – I believe it was about five minutes before the connection to switchboard was able to be made so they could announce the Code White.

By that time, we had been trying to subdue this very aggressive male patient and we were exhausted. And not only that – two of the nurses were very badly injured. One's face was swelling as we were holding this guy down. We were very concerned about his safety because his eye was swelling, and it was bruising up. The other nurse had hit her head quite hard on the wall, and she was having a hard time. She was even having a hard time with her balance – while holding this young man.

So, after about five minutes, people started to arrive. And the first people were the two security guards. They assisted in trying to hold the patient down – even though they are not supposed to. But they could see that we were struggling –and more people arrived from other units – all nurses. And they are in that situation where they are showing up at a crisis and trying to figure out how they are going to manage it.

With the help of others we were able to get him up. So, each unit has – or should have – a seclusion room. But our seclusion room was occupied. So we were not able to transfer the patient into the nearby seclusion room. Instead, we had to transfer him to another unit. So now we still have this aggressive patient, who's fighting all the way, to take to another unit. And that in itself is scary – because you go from our unit into a big hallway, and you're locked between two doors. And anything can happen at that point. Finally we did end up getting him secluded.

- I got my shoulder hurt during a Code White trying to seclude a patient. He twisted my whole body.
- I was on a Code White, so I had to run. And I didn't know what to expect when I got up there. He had the doors ripped off the bathroom, whipping them down the hall. Every staff was scared. They were all hiding behind closed doors waiting for him to calm down. I know this client very well and these staff didn't. So I calmed him down. I walked right in the bathroom and said, "You have to stop this." He was trying to choke himself with a belt and he started to cry when he saw me. He started hugging me and he said, "I want my mom." So I said, "Maybe we can call your mom after you calm down. Let's go to your room and have a glass of water and talk about it, and sit on your bed."

  And he said okay. So the staff followed. By that time the police were already called, which I did not know then, and they were on their way. So, I went into the room. Everyone just stayed back – just not to interrupt. So I sat with him on the bed. And I said, "Okay. I'm going to come back and check on you. Are you okay?" He said, "Yes. Goodbye."

  When I went to get off the bed, he grabbed me and pulled me on his bed so quick, and took my arm and put it in his mouth so quick, and bit it. So hard. And it hurt me very, very much. I screamed my head off. Because he also had a very bad mouth infection. Then the police ran in. It turns out they had been in the hallway right outside the room listening. So they came and pried his jaw off my arm. He was like a pit bull almost. I had to go straight to the hospital and get a tetanus shot.

- It can be pretty scary. I have gone to codes where patients have had weapons. And trying to figure out what our safest approach would be to ensure everybody's safety in those circumstances. A lot of times I know we have called police in the past to help with those situations but I know the police have been told they are not to touch the patients – unless someone is actively charging the patient. So it doesn't do much good to for us to call unless someone is actually charging the patient.
- During a serious incident we called security because in the past we had been specifically told not to call a Code White . . . because the whole team comes and you don't need the whole team. We were told, "Just call security and maybe they can de-escalate the situation."

  When I was questioned about the incident after, I was asked, "Why didn't you call a Code White? Why did you just call security up here stat?" I said "because for years you guys have been telling me NOT to call a Code White. I called security stat – like you told me to do." So all of a sudden that had changed, and it's on me.
- Once you hit that alarm there is a delay before it is announced. And then, after the code is announced, typically it would take a couple of minutes for staff to get there, depending on who responds. There is supposed to be somebody responding from all the units, and the security. So obviously the units that are closer to where the alarm was called get there first. And then people start trickling in – the further along you get. But the immediate – it's the immediacy that's the problem. With most codes, you need help there right away. And any delay getting people there can be life threatening.
- We're healers. We're trained to take care of people. We help people. We are there for them in their

"We're not trained to do this stuff"

The idea that nurses and other health care workers should act as security guards, physically restraining or tackling violent patients – sometimes being drawn into life threatening defensive struggles – seems unthinkable. But for some health care employees, it is an all too common reality.

last days. We keep them pain free, as much as we can. That's the nursing that I went into. Not what we're doing now. Not being police, not being security. Not rolling around on the floor in fights with patients. It's not part of nursing. And that's what we need to change.

- We're not trained to do this stuff and people get hurt. Nurses working in federal correctional facilities don't have hands on the patients. They have guards. They have squads. The nurse goes in and does what they do in terms of medication, talk, assessment. There's no hands-on. But here it's a duty that we do. And I don't know where it came from.
- I have never taken any course about rolling around on the seclusion room floor with somebody when they're trying to punch you. It shouldn't be part of the job.

"It affects the therapeutic relationship"

Health care workers are trained to care – not to grapple with violent patients. The basis for an effective therapeutic relationship is shattered when the role of caregiver becomes that of a guard or police officer.

- Why do we continuously have to do this? I'm not a police officer. I don't have the special training to deal with somebody who's that huge and psychotic. We're not allowed to be aggressive, like specially trained people are. This is going to continue to happen as long as they have us being security officers, being police. It should never have happened. I don't know how it got this way.
- I'm a nurse, not a guard, not a police officer. It's difficult to deal with. We had a patient come right over the desk and grab another staff member and held them up against the wall. And we're grabbing their limbs . . . Just the strength these people have when they're in that moment of aggression.
- Sometimes I think, "Why am I being punished for trying to do a good job to the best of my powers, and for trying to make sure that my patients have a good outcome in their recovery?"
- We've come so far afield from what nurses do – that caring and compassion – to this. The fighting. It's not what we're supposed to do. It also destroys the therapeutic relationship between you and the patient.

  Having to physically restrain – physically fight with – have these physical encounters all the time. It becomes a major part of the job. It's not part of nursing. It affects the therapeutic relationship you have with a client. It's very difficult to gain somebody's trust after you are perceived by them to have hurt them. Which they do. Believe me, they remember. They remember if you've done something physical. It affects recovery. It affects how you do your job. It affects how they respond to you.

  Overall, it makes for bad outcomes, bad recoveries. And that's what we're all about – providing the optimal recovery for somebody. And I don't think we can do that when – sorry I hate to say it – but they think of us as the bad guys.

  And I'm not saying we are always involved in crisis situations and physical encounters – but we shouldn't have to be involved. We should be the people there afterwards. We should be the people that are there doing the debriefing, doing the talking, giving the medications. The people asking, "What can we do to make this better?"

  We shouldn't be the people who are talking to them after we've had a hold on them. After we've probably destroyed any therapeutic time we've had with them and you have to rebuild that again. You don't know how difficult that is. They just think of you – not as a person who is part of their recovery – you're just the person who was holding me down, had me by the arm, or was putting me in a seclusion room on a mattress. Memories last.
- I remember a couple of years ago after we secluded a patient – a very difficult young gentleman who got better. He ended up being my client and we would meet. But he looked at me across the table and he said, "I will never trust you. All I remember is you holding me down and carrying me into the seclusion room. How can I trust you? You were the person who did that to me."

"Nurses are putting their licenses on the line"

Health care workers are concerned that, if they are forced to act as security personnel, it might threaten their professional status.

- The College of Nurses' mandate is to protect the public. When we have to get into these crisis situations and involve ourselves in physical encounters, we are accountable to the College of Nurses of Ontario if something happens to that patient. For example, if a patient is hurt during a seclusion or during an emergency intervention, and he decides to report the nurse, the College would launch an investigation and they would look at what happened. Not from a standpoint of what the nurse had to do to protect themselves. Just from a standpoint of what was the nurse doing in terms of the standards of practice. Nurses are putting their licenses on the line when this happens.

  If you are involved in a crisis situation and something happens to the patient, the College is there to protect the public. They are not concerned with the situation surrounding the event. If a patient gets hurt and it's somehow caused by a situation involving a nurse, the nurse could be charged – have his or her license suspended, have it revoked, have conditions put on it. They never intended us to have these types of physical encounters with patients.

"When these incidences happen, the last thing you feel is supported"

Employers and their representatives have a responsibility to support their staff. Health care workers who have experienced violence face additional emotional stress and frustration when supervisors fail to provide much needed support. While some can be very sympathetic and helpful, others seem to be more concerned with suppressing any further fall-out from incidents. The policies and reactions of the compensation system can also make victims of violence feel further victimized.

No support

- We get veiled support from the hospital. They're always offering employee assistance programs. But that doesn't solve the problems that created the incidents in the first place.
- They say, "We're here for you. We'll do anything you want. We'll do anything we can to keep you safe." That's what they tell the public. It's all about quality care and safety. When these incidences happen, the last thing you feel is supported. You get the mandatory calls from the health office asking, "Are you OK? When are you returning to work?" This kind of thing. It just makes you feel almost re-victimized. They make the process to recovery so convoluted and difficult that people just want to avoid it all together.
- I find the employer is more concerned about the patients. And not traumatizing the patient if we have to do hands-on with them. And to decrease or eliminate seclusions, which I feel is very unrealistic in our line of work. They are not concerned about the staff safety. I think that staff judgment in terms of when we feel the patient needs to be secluded should be taken seriously. We need to not be told we did something wrong and that a patient shouldn't have been secluded. We're penalized because we did what we thought was appropriate at that time to keep everybody safe.

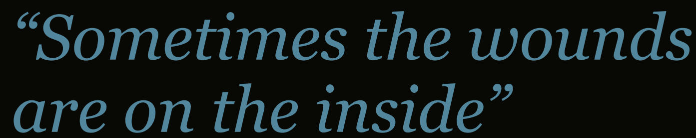
- We need support from upper management in keeping us safe – not making us feel we did something wrong if we got injured – and not discouraging us from placing charges on patients when we feel the need to do so. I think there needs to be a lot of focus and education on staff safety, and letting the staff know that they are supported, that they can talk to management about it – and knowing they are there to support us. Because if we don't feel supported, we don't report a lot of things that happen to us because we fear we'll just get told we did something wrong, or we didn't deal with the situation appropriately.

- After the incident, I never got any debriefing. I did not do the incident report. Literally nobody asked me what happened. They only asked me – when I was in shock – whatever bits and pieces I could remember. That was what they wrote on my incident report. I don't even know what they wrote. I have no clue. And I never got any debriefing. No one even sent me a card saying, "Hope you're feeling better soon." Nothing. I was - whoosh - out the window. I was told, "It's your fault." That's what I was told. It was my fault that I got beaten up.
- Managers will minimize violent situations. They'll say things to you like, "Well, take a look around. This is where you work. You have to expect violent situations. You have to expect you're going to get punched." Well, you know? That's unacceptable.
- The first thing that's usually said is, "Well, what did you guys do to deal with the situation? What could you guys have done differently to help this patient stay settled and stay out of seclusion instead of letting us know that we did the best we could do? And supporting those that were injured." Looking back on an incident later on, and saying, "What are things we can do differently next time?" For sure. But during that critical period right after, when people are really shaken up, or injured – they need that support

- It's unacceptable that a manager will say to you, "Why are you filling out a form? You're not really hurt." They don't see past the physical hurt – that someone may be psychologically hurt. And I've seen that. So, it's kind of the culture of being chastised by your parents. They make you feel childlike for making a complaint. And people are afraid. They don't want to come forward and say too much, because the managers are so critical of their input. The managers control these situations, but they're not there. They're not involved. They don't see it. They're not getting punched. They're not having to hold down these people. And you know it's not right but it is the culture. People are afraid for their jobs. I heard one manager say to an employee, "If you don't like this part of the job, then get out."
- The supervisor said, "Okay. So fill out an incident report." And I said, "I'll be filling out a [hazard report]. And she said, "Why would you be doing that?" And I said, "Because I've been instructed to do that by Occupational Health and Safety." And she said that there was no assault that occurred to me. And I said, "Yes there was." And she said, "Oh come on. You weren't hit." And that's exactly how she said it. Literally I was in the nursing station, I made sure my whole other team was there when I was speaking with the supervisor. And I said, "Are you telling me not to fill out a [hazard] report? And I said "And I WILL be calling the police. And she told me, "No." So I said, "You're telling me not to fill out a hazard report, not to call the police, just to do an [incident report] online?" The frustration that I had with going through the situation that happened with the patient – and then dealing with the supervisor – was extremely frustrating.
- The staff needs to feel supported in situations where people are being injured, and we don't.
- I still see the person who assaulted me on almost a daily basis. I see him in the coffee line. I see him when I come into work. I see him when I leave work. If he had hit a doctor, I believe he'd be out of there within the hour! There's a very big double standard.

ADMINISTRATIVE ROADBLOCKS

- The administration is well aware of the violent situations we deal with, but nothing changes. They even seem to put up roadblocks in the health and safety committee process.
- You need to hold accountable your senior management team. Be proactive, not reactive. How many nurses have said that – I'm sure many, many times? Let's try to be proactive here, not be reactive. The hospital never seems to work that way. It's always reactive. I'm quite grateful – I have a great manager that I work with – I'm quite lucky that way. But she's always under a bigger umbrella that she's accountable for.
- You know they wanted to pay me a percentage of my wage for the day I wasn't there? The way I look at it is that I'm taking a pay cut for being assaulted. So you feel almost re-victimized.
- I know the employer always says, "We had a debriefing with the unit after that incident happened." A lot of times the Joint Health and Safety Committee don't get invited to these debriefings, so we don't get to see what's being said. If we think there's something else that needs to be done during



“Sometimes the wounds are on the inside”

The lasting impacts of violence can be obvious or hidden. Physical injuries can impact every aspect of one’s life. The inner pain – the effects of post-traumatic stress disorder (PTSD) – can also be debilitating. And psychological scars can be made more unbearable by the sense that one is alone and misunderstood.

these debriefings, we can make a recommendation to the employer – but we’re never involved. The employer tries to limit the involvement of the committee, which I think is a really big mistake. Because we’re both there for the same thing – the safety of the workers. We’re not there to fight with them – we’re there to work with them. And if they would just allow us the time and the material that we ask for to help, and investigate, as per the Act, I think we would be able to help them in some of these things.

Other than the debriefings, I know that they always offer the Employee Assistance Program (EAP). But that’s very limited, and a lot of staff don’t like to attend the Employee Assistance Program because it’s linked to the employer.

- Sometimes – with these physical encounters, I can tell you – the wounds are on the inside. And they are a lot deeper and a lot harder to deal with than on the outside.
- Legislation at Queens Park now covers firefighters and police for post-traumatic stress disorder. It needs to cover other front line workers, including nurses. I think it’s a mistake if it’s not, and I hope somebody is advocating on our behalf in terms of upcoming legislation that provides clearer guidelines for PTSD. Because it’s something that gets brushed aside.
- We do have some staff that have been hurt severely. Some have never returned. We have some that are still off and we’re not sure whether they are going to be able to return or not, just because of the severity of their injuries. And because of the trauma playing back on them when they come near the site where they were assaulted.
- It’s really hard to deal with every day. And I remember the WSIB rep – he sloughed it off. He said, “You should be back to work.” But every day I deal with the post-traumatic stress from it. They don’t get it - because they don’t live it. I have huge anxiety problems because I hate to go to that unit. It was the wildest day I ever remember. I’ve never had a code like that in my life.

- If they've been off, then they're getting the phone calls, "When are you coming back to work? We've got modified duties – when are you going to do this?" And that plays a role with an individual who's been traumatized and can't get it out of their mind what's happened to them. And when they think about work it all comes roaring back and the panic starts again.
- What can I do? So now I've been fighting with WSIB. WSIB and the hospital have re-victimized me. My case worker phoned me and said, "You're going back to work on Monday." I said, "What?! I'm not ready to go back to work. Who said I was ready to go back to work?" And she said, "I did." I wasn't physically or mentally ready to go back to work. And work was not ready for me either. They had certain restrictions on me returning back to work . . . there are lots of things that they didn't want me to do. They had no place for me to work. So they had me do filing.
- The people at the top are just walking away. And as soon as our poor staff get on WSIB, everybody just washes their hands of them.
- I'm currently at work on modified duties. I'm getting WSIB. I am getting counseling for post-traumatic stress disorder - PTSD. The latest assault almost broke my nose and caused extensive bruising under my eye that took a while to resolve. It was quite traumatizing - it was horrific. It is on tape but I have not seen the tape and I don't wish to see it. Maybe further along in my therapy I may look at it.
- I don't engage spontaneously with patients any more. I just sort of keep my head down and walk out. It's even affected me in the community. This gentleman was holding the door open for me. He looked like he may have been a mental health consumer . . . I actually veered away from him and went to the other door and left. And he looked over at me and he said, "I was just holding the door for you." And that made me feel awful inside. It made me feel that's not the person I am. You know? So it's changed my outlook.

"You take it home"

Family members and loved ones of health care workers can become secondarily victimized by workplace violence.

Hopefully I'll be able to get that back again. But I don't know if I'll ever return to the way I was. I'll try. But I'm certainly in a heightened state of awareness now. And I don't want to go to codes anymore. I don't want to do seclusions. I don't want to deal with people like that now. I don't want to get hurt anymore.

- It hurts a lot to see one of your co-workers injured or struggling with what happens to them in the aftermath of an incident – with the hospital, and the bureaucracy when you get injured – with the paperwork, and the phone calls. You feel you are almost penalized for being injured.
- It's just a shame that people have to go to work and get hurt. Because you don't leave home wanting to get hurt. And it's no different than being a bus driver, or a mail carrier – nobody goes to work to be hurt. And we have families. We want to go home to our families – and enjoy our life with our families instead of being hurt.
- You know, when you go home from work and you have children who see you come home with a black eye or broken limbs, it affects your family psychologically. It also affects you psychologically. It's like getting in a bad car accident –- it takes a lot to get back in that car and drive again.
- It's toxic. It makes you not want to come into work. And those little things start getting to you . . . and you take it home. When someone rips you up and tells you you're worthless and you can't even do your job. It's only happened a handful of times, but every single time it's made me feel that I'm not good enough. And you take it home. As awful as it is, you take it home.
- I find that people who are cognitively intact – people who are just like you and me, who are able to function daily, have normal conversations; they're oriented in all hemispheres – those people are the ones that verbally can rip you up to the point that they cause you emotional turmoil. And you take that home with you.
- When you go home and it all sets in that day . . . and you're having your own family issues to deal with – children, marriages, divorces – who knows what – and then that on top of it? That's where it affects you – when you have to leave, and then deal with the rest of your life.
- You go home and your family has to deal with what's going on with you. It's been a couple of months and I still have to deal with it at home. My spouse is worried if I'm going into work. Or my child will say, "Don't get hurt today."

Health care workers are becoming increasingly frustrated with the lack of concrete attention the issue of violence is getting from the government, their institutions, and their supervisors. There is plenty of lip service, but little change. The strategies and policies being put into place seem to be largely ineffectual.

- I was attacked by a patient that left me with a black eye, which is pretty devastating – to go home to my family and have them see me in that state. It was pretty alarming for them, and they're still kind of struggling with it. My young child has made comments like, "Are you going to get hurt today?" when I'm leaving for work. To me, that's tragic . . . I don't know if she'll forget about it over time, but she hasn't forgotten about it yet. And it's been several months.
- For months my son would say to me, "Mom, you're not yourself. Why don't you quit there?" He says, "It's not a good place for you to work. And I don't want you end up dead one day." It affects my whole family because when they see that – see me so upset when I come home, and they hear on the news that somebody got beat up at the hospital - it's hard on them too. It's not just the staff. It's hard on everybody.
- Every day there's something. Sometimes it might not be a Code White. Sometimes it's just somebody yelling and throwing a chair. And sometimes we can deal with that and they can be de-escalated. But sometimes they can't. It's hard to come to work every day and walk onto a unit and hope and pray that nothing happens – usually it does. So I take it home.
- At some point I think that people need to get stronger about this issue. Everyone is afraid of the violence.
- I truly wish that the employers would really look at ways that workers can go to work and never have the fear of being beaten, or spit upon, or face the threat of being stabbed, or verbally abused, or told that they're useless and have no meaning in this world.
- Because I believe that someday there will be someone who won't go home to their family at night. I've been in these violent situations and it is a real possibility.
- If they don't turn it around, what happens next? Do we have to wait until someone gets killed before they do something?? It's not acceptable. It's not acceptable to me, and it's not acceptable to the people I work with either.

- Incidents that occur follow a similar pattern. There's an identified risk that's noted and observed. And yet nothing occurs. And it almost takes a critical incident for somebody to step forward and say, "Well, now let's do something about this."
- I think there needs to be a concerted effort on behalf of nurses' representatives in Ontario to talk to the government to get some sort of legislation to say this is not part of our job. Nurses do not engage physically with patients. It's not therapeutic. It also risks their licenses. And it's not in any way something we were trained to do.

- Nothing is going to change until we get some legislation, until we get somebody to actually identify and say it's not right what nurses are doing in terms of physical altercations with people.
- The culture of the employer has to change and the culture of the work environment and maybe how more senior middle management people, who may have been around for many, many years, who see all of this as part of the job. That has to change. There's no ifs, ands, or buts about that. It has to change.
- I think that violence in the workplace… from what I've experienced… that a lot of the issues can be dealt with from having extra staff. There are a lot of the verbal threats – someone threatening to throw food at you – or literally throwing food at you – a lot of those frustrations could be avoided if we had staff to meet needs in a timely manner.
- And I pray every day when I go to work, "Please don't let anything happen to any of us." To see people get beaten up - - and hear them get beaten up. When does it end? Does it end when somebody gets killed?

What’s the Answer?

“There are manageable ways to mitigate violence”

How can the problem of violence against health care workers be fixed? There is no single solution. It is a complex problem requiring a complex improvement approach. There are some key issues that health care workers have identified as essential, including adequate staffing levels, reducing patient frustration experiencing anxiety or long wait times, security measures such as alarms, effective training, trained security, control procedures, zero tolerance policies, and the reporting of all incidents.

- You know there are manageable ways to mitigate violence. There are tools that could be used. But they have either become eliminated from our box of tools, or we are not encouraged to use them or we don’t get supported in using them. Over the past few years it’s made the problem worse.
- I’ve heard nurse managers and directors challenge our clinical judgment around our decision to seclude a patient for the patient’s personal safety. Or the safety of other clients. Or the safety of staff. The hospitals have gone to a least restraint policy, so you are chastised for making those sorts of judgment calls.
- They don’t medicate patients with dementia as much any more. It’s hard in geriatrics. They used to medicate them more. The use of restraints is now considered a form of abuse, but sometimes WE want it as a safety measure. But we don’t have a say. We wish we could restrain them to calm them down at times, that’s for sure. So you have to be careful because they are unpredictable.

- Some [forensics] patients have no discharge date. They have nothing to lose. They get hopeless very quickly. So, what happens when they get hopeless? That's when the violence starts. They're not understanding. So they look at us as the jail keepers, right? Not as the nurses.

- All the problems they're having in the emergency department with violence, and strapping people down to gurneys, and having to securely watch them. That stigmatizes people with mental illness. Why not deal with their frustration by assigning people to offer them refreshments, sit with them, and reassure them. Tell them, "I know you've been waiting a long time for the doctor." And check for them to see when the doctor might be coming.
- I think management needs to follow their policies. Policies are great when they are in writing, but if you don't follow them, you might as well not have them. If you follow them and implement them – statements in your policies that state, "If the violence persists, from a patient or a family member of a patient then they will look at removing the family member and not allowing them back on site." Or removing the patient from the hospital. I've NEVER, ever heard of anything like that.
- I get angry at the hospital. I don't get mad at the clients because I understand it's not their fault. And I try my best to calm them down, by trying every avenue I can with them. There are too many admissions, not enough staff. A new client comes - they place them onto the floor and just expect us to handle it.
- I truly think the hospitals need to look at the type of training they're providing to the staff. And I think it needs to be consistent training all across the board. And if you have a group of people who are getting training and you're still seeing a trend towards a lot of incidents, I think you truly need to look at the training you're providing.
- We have one seclusion room. But it's hardly used for geriatric or dementia patients. The allied staff – social workers and physiotherapists – believe that's a form of abuse. But they're not the staff on the floor!

- Bolt down those chairs! Bolt down those tables! Don't allow them to have drawers in their bedroom that they can rip out! You can have chairs. You can have tables. But they don't have to be moveable. I totally believe in patient's rights – but that doesn't mean that your chairs have to be moveable! And when you've got a six foot three guy, you shouldn't assign the smallest nurse as the primary. You have to use your judgement as well – who is appropriate for who!
- And we need proper alarms to alert staff of violent or potentially violent situations.
- And we need the right to refuse unsafe work . . . clear legislation in the health care regulations - in the Health and Safety Act

"We need more funding"

How do we achieve these measures? The first thing to tackle is the idea that violence is "part of the job." It is at best, a defeatist attitude. Violence is not inevitable nor is it acceptable. Violence can be prevented. Violence can be controlled. Achieving an end to violence will take a concerted effort – complete with adequate funding and full and respected input from those most at risk.

- If everybody who still has the attitude that it is part of the job changes their attitude, then maybe we can do something about this. But everybody needs to band together.
- And let us have some input. And get BACK to us! Really, that's a big problem. You have a big incident. We debrief or review it and then they go to their side and they review the whole thing, do their root cause analysis without any input from the unions. And then, they don't get back to the front line staff. So then an incident happens again. Why? Because - you didn't get back to us. There could have been something you found out in the investigation that could have helped reduce the violence. Bottom line. But no. It's a big secret – just for the elite group.
- I don't think it's any coincidence that, at the same time there's been funding cuts and budget freezes, tons of programming in the hospital have been cut. And patients' having idle hands is not a good thing. We have a vulnerable client population. And when they don't have anything to do, they find negative ways to fill the time – and that leads to pretty hairy situations that don't need to happen.

- Anybody knows that in mental health, the quicker you get treated, the better the response. Wait lists for mental health beds are huge. It doesn't help that we've had zero hospital funding for the last four or five years. So with cuts, no beds, waiting longer, getting sicker, when you come in . . .
- There's not enough money in health care. They just keep cutting away, and spreading us thinner and thinner and thinner and we're burning out and having our own health issues. We're tired. We're very tired.
- I can't emphasize enough the fact that employers need to work with their Joint Health and Safety Committees. Because I truly think that by working with them instead of against them, we may be able to resolve some of these things. Or then again, we may not without the moneys from the government that we need. And even if the government does provide the money, the workers are at the mercy of senior management and the CEOs. Will they make sure that that money gets allocated into the areas it's needed?
- We need more funding from our government to fund the hospitals to make sure we have adequate staffing – to replace sick calls. It all starts from there. It all kind of trickles down. We need the funding for your front line staff, not for building new buildings all the time. For front line staff. And Ontario does not have that. There is very poor funding to our hospitals.
- I would say that budget cuts are high up on the totem pole because if we had the money, then we would potentially have the staffing. And your patient care plan would then reflect it. You need 2 people, or 3 people to be dealing with this individual. Now when somebody phones in sick, they decide they're not replacing anybody. So the unit is understaffed. And if you have a Code White, you have a limited amount of staff while it is in progress. They need to start staffing the units appropriately. And again, that's budgets. That's a money issue. It's the government not providing the hospital with the amount of money they should be providing. And if they had the money they would be able to provide the training that is necessary for the staff and the alarms and whatever they may need.

“We need more staff”

Unquestionably, an important component to prevention is adequate staffing. Adequate staffing means more time to devote to patients, thereby reducing anger and frustration. And more staff provides safety in numbers.

- They really need to put their money where their mouth is. And a lot of the issue is staffing. The staffing issue is a huge, huge issue.
- We work short quite a bit. Our patients do require a lot of assistance, and do need care. But when you’re working short staffed it’s hard to get to everyone. I feel people misunderstand that we need our breaks too, so that we can re-energize ourselves to go back up onto the floor and do our jobs of caring for the patients. And it’s not only the patients that we care for – it’s also their families too, which is very important. Because we need to care for everyone in order to have a good outcome.
- I’m fortunate – I work on a floor with colleagues who are amazing, and we endure everything together. And you can lean on each other. And I think that’s very important. But when you’re short staffed every day, it burns you out.
- You can’t expect the nurses to work short. And I’m sorry – it’s not just nurses. It is all health care – dietary, cleaners, linen, whatever. First sick call? Not replaced. You can’t do that.
- Violence occurs because we are short staffed and not meeting patients’ needs in a timely manner, even though we are physically unable to, and even though I’ve missed my morning break. I’ve been - and my co-workers have been - running around the unit trying to play catch-up and making sure that all the things are done in a timely manner – to the point that staff’s blood pressure is up. They are anxious, they feel dehydrated. They haven’t had a bathroom break in hours because they missed their morning break. And then to be cussed out by a patient, or physically having things thrown at you, because you’re already run so thin, and you’re trying to do your best, but it’s still not good enough.
- The trend is alarming. It’s gotten what I would perceive as worse over the years. The violence has increased. The staffing has not increased to reflect that. And it’s becoming quite the problem in the last few years especially.
- The budgets were that bad that we weren’t replacing sick calls so staff were always working short. Plus you make the nurse feel guilty about calling in sick – because you think about your team mates – you think about the people you work with, so you may come in when you’re not feeling well. You know the hell they go through when they work short. It just increases the stress; it increases work place illness. It increases work place accidents, in terms of sharps and needles. You’re tired; you’re working harder because you don’t have staff.

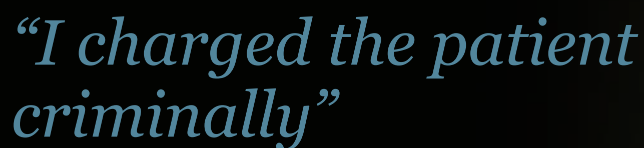
- One of the things that's been going on the last 3 to 6 months is they're not replacing nurses who call in sick. I went in last week – two short! They refused to pay the time and a half because it was a weekend and it would be too much money. So they say, "No – you're just going to have to work short." We always pointed out to them that it risks the safety of the patient. Because OUR safety has never seemed a priority to them. But if we brought up patient safety it usually would help a little bit. It just didn't seem to help anymore. They couldn't find RNs. They couldn't find RPNs. They can't find them. They don't even want to come in for overtime half the time – because it's just not worth it. "You're just going to have to work as a team, and work two short now" we were told. It's impossible. You just can't do it.
- You've got to eat, so when you divide up the lunch hours, the minimal amount of staff is on the floor. So for example, when I'm on the floor there are two staff. And when I'm doing rounds, then there is one other staff. And if there's a code, the expectation is that some person has to go to the code. That leaves one staff on the floor. I don't know of a more dangerous situation. If something happens to that staff person, there is nobody else.
- People who are stressed can't come to work. But they DO come to work – because they are good people and they don't want to let their co-workers down. So even if you're sick, sometimes you come in because you know you're not being replaced. And the employer plays on that. They know that. It's a horrible situation. It's like pitting the nurses against each other.
- We definitely need more nursing staff. It would be good for us as nurses to have more staff. And it would be good for the patients. Because hopefully it will alleviate some of the anxiety that people are feeling. Families are demanding more too, from nurses. And it's very hard because you are trying to be everything to everybody.
- We need more nurses to make sure there's always someone there with us. Working with a co-worker might help eliminate some of the violence problem.
- We don't have enough staff to have two staff members go and check every patient . . . Sometimes you don't even have time to see your own patients that you were assigned during the day because you are too busy with the others.
- I would like to see more experienced nurses. More nurses on the floor than what we have - especially forensics intake units - the ones that have the potential to be more violent.
- We need more staff for sure. I feel the patient/staff ratio – the more patients you're working with, the more at risk everybody else is of making an error or being injured.
- I honestly believe the biggest problem is we have lack of staff. We absolutely need more staff. Just one or two extra staff - that would be wonderful in that environment. It's an unsafe environment because we have unpredictable clients. Don't go by what the hospital down the street is doing – we have special clients. We need the staff for safety. Consider that. And maybe individualize each floor. On an acute floor, we need the staff. And don't make them work short. And get everyone on board and have a multi-disciplinary team that all knows what to do.

- The people who work in the schizophrenia units do deal with the patients very well, but they are so unpredictable. And the intake units are wild – stuff's being thrown all over the place. I've seen computers thrown off the desks – the ones not guarded by glass. Hopefully you have enough team members to deal with them.
- And honestly, I think it would make such a difference if we had enough staff – and I think patients wouldn't be as frustrated – we'd have more face time with the patients, to establish that rapport, to build that relationship with them. To get to know them on a personal level too. . . But with how thin we're spread right now? There's no time to get to establish that rapport. Or even meet all their needs in a timely manner. And that causes huge frustration from their end. Huge burnout and frustration from our end. And that makes a very unsafe work environment when everything's so volatile.
- We're spread so thin. We're always asked to do more paperwork. The hospitals don't pay overtime if you can't get it all done in a day – so the patient care suffers. Because you spend time doing these more arbitrary tasks, as opposed to paying attention to the clients and you being able to notice any triggers that could lead to escalation - and being able to intervene early. These days there's not as much time to observe to that degree. And it leads to more incidences where someone may have been escalating and it wasn't really noticed as well as it should have been - and by the time you do notice it, it's already too late.

"The security presence is lacking where we work"

The role of security belongs with highly trained security personnel. The number, training level, and responsibilities of security staff needs to be tailored to the particular needs of the institution or unit.

- I think we should have more security – more guards. I think we should have a dog to detect drugs, at least a couple times a week for a while, until some of the drug issues start to come down.
- I think our employer's policy is to have the least security possible. They don't like it. They consider it custodial. They consider it contrary to treatment. I think it's contrary to treatment to have the nurses doing what we're doing in terms of physical encounters. It's not therapeutic, and it's dangerous.
- These security guards only make minimum wage so they send us in first to a code. They're security; that's what they're there for; to help us, you know? But they don't. They just stand in the corner. I don't know what to say about them. They're people, they need a job. There are some good guards there – and they do well. But the majority of them don't. You need to have people who are experienced with mental health patients. It's a huge issue.
- The security presence is lacking where we work. They're not hands on. And that doesn't help the nurses in terms of working with those individuals after an incident. Because when you've had to restrain a patient and be physical with them, it makes it harder to work with them afterwards. It puts you at risk for further incidents with those individuals.



"I charged the patient criminally"

There is a strange double standard that encourages citizens to criminally charge perpetrators of assault but discourages health care workers from doing the same. Some employers do support laying charges and some health care workers do so on their own, sometimes with positive results.

- To me, a worker should have the right to call the police. And when you read through the hospital policy on violence, it doesn't even state that. In some parts it states that it would be security personnel that would make the decision whether the police should be called. In my eyes, if a staff member wants to lay charges, then they have the right to lay charges. And if they feel they want to call 911, they can call 911.

- The next morning I phoned my boss, and I said, "I feel like phoning the police." And he suggested I shouldn't phone, "Because that would bring the client to our catchment area. And we don't want him in our catchment area." But another person encouraged me to do what I felt was right for me. So I did phone the police. The police came to my house – spoke to me for a good hour and a half. The police took everything I had said, and went to the chief of police. And they decide NOT to lay any charges against him - because he already had charges against him and he would always be considered NCR - not criminally responsible – for his behaviors. So it doesn't matter how many people he beats up – he will never be held responsible.
- I personally did charge him. Luckily for us, we're in a unit that does have video footage. So they were able to show clearly that, unprovoked, he just assaulted a number of us. So I mean, if it wasn't for that it's a matter of "He said - She said." And the hospital doesn't really encourage us to charge patients. I think they shouldn't really have a say.
- The police came to my house . . . I filed the claim to press charges. I've never done that before. But the type of assaults, the type of environment we work in now – you can only work so long without it affecting you as an employee.
- We need to put pressure on the crown attorneys and the police forces. And it's not the front line police. It's the sergeants who say, "Go ahead with these charges" or not.

"We're under-reporting a lot of assaults"

Research into violence suggests that reporting even minor incidents and threats can lessen the chances of more serious events occurring. And inadequate reporting limits the information needed to make improvement.

- I have a feeling we're actually under-reporting a lot of assaults, especially the verbal assaults, the threats, that sort of thing. There have been a tremendous amount of unprovoked assaults on nurses. The stuff we deal with on a daily basis – the threats, sometimes spitting. There are times I know for a fact that nurses have been kicked, scratched and don't report.
- We still have a lot of non-reporting. I'm not sure if staff were afraid to report it, or they're thinking it's part of the job. I have heard staff say, "Well, it's part of the job."
- You hear it pretty well daily. Some people say, under their breaths, or at the nurse's station, "I'm effing tired of the abuse around here. I'm sick and tired of getting kicked in the leg." So many people don't even report it anymore, because it's just little kicks – like a client will walk by and kick you. The supervisor will say, "He does it all the time. You'll be sitting at the computer all day just doing incident reports." And I say, "Good. Let's do that." But, it's there again – the shortage of nursing. So those little things aren't being looked at and they become big things. And injuries occur.
- We're spread so thin. And there's not even any time to complain. So if we're short, and I get my arm twisted, and I haven't even had my break in the morning. Or I'm running around and I've got to get the charting done. Or that person needs their shower. Where do you fit in the time to do an incident report? Where do you fit in the time to take a step back and say, "I'm a person too? I got hurt."

- It's just sort of been under the surface – Hush, hush. Nurses are good people – you know, we don't report patients when we get physically assaulted – it's just part of your job. But I've always said it's not part of the job. For some reason it's been made part of our job.
- There were things that happened like that on a fairly regular basis. But we never reported it. I just went into the nursing station and said, "Oh my god, this guy." And they took me off his assignment.

"I feel I need to speak out"

Many health care workers do not feel safe contacting the government or speaking openly about conditions at work and asked that their identity be carefully masked. The recent firing of a nurse in North Bay who was accused of commenting publicly about the issue of violence has had a chilling effect.

Speaking publicly, while protecting the confidentiality of patients, about dangers at work should be a protected right. The head-in-the-sand approach that is decreed by management of some health care facilities will not advance the cause.

- Please keep my identity hidden. I don't want to be out there. Believe me – you'll see me at the employment office. People even call the Ministry of Labour Board anonymously. Because everyone's scared – that's for sure. We're scared to lose our jobs. No one talks.
- I spoke out about the violence and the importance of reporting it. Afterwards, my manager called me and said, "You'll have to come in and see me." And I said, "No, you know I'm on the night shift tonight." And she said, "It's disciplinary and you need to get union representation. One o'clock." So I called my union and said, "I have to go. I need representation. What's up with this? Why am I being targeted?"

So I went in. They asked me four or five questions. One of the things they specifically asked me was, "Did you read the Media Policy?" And I had. Two weeks prior. It had only been out recently. And I said, "Yes, I did." And they asked, did I speak directly to the media? And I said, "No, I didn't." Then they asked me who else was speaking at the meeting. And I said, "Everybody. And I'm not comfortable answering that."

Then I asked them to leave the room. And I spoke to my union rep and said, "I'm not telling them who else was speaking."

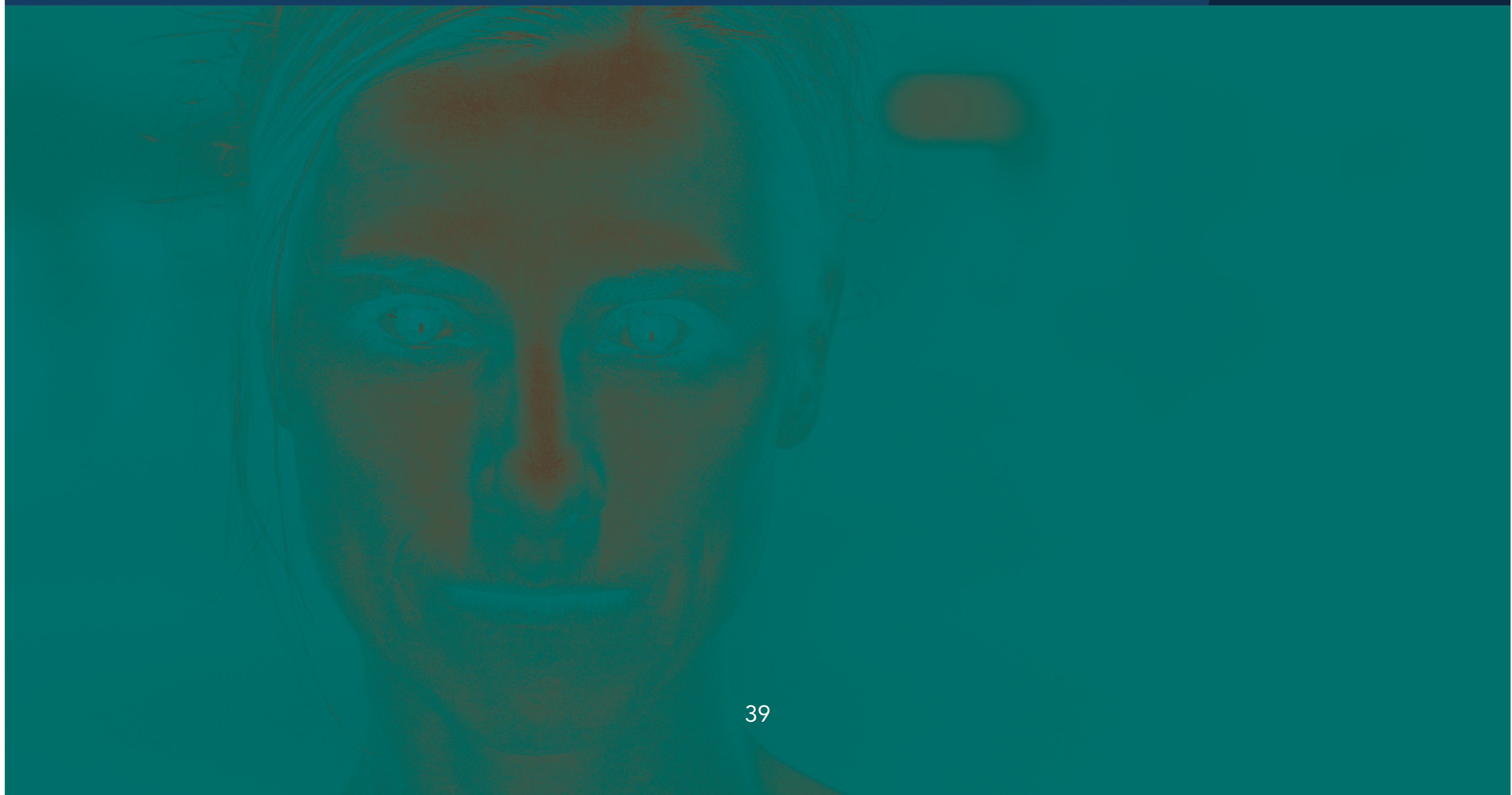
Then they came back in – and decided to terminate me. I believe the letter said, for "making the hospital and the patients look bad." Something similar. And they tried to read me the letter – to further humiliate me – that's how I saw it. And I said, "No. Don't read the letter. We can all read." I believe that this is bigger than me, right? This is not just about me. It was to shut everybody else up. What a primitive strategy. Pick the leader – shut them up – and then scare the hell out of everybody else.

- I just want to make sure I don't say anything that's going to tip the employer off or they're going to come after me.
- I'm worried that I would lose my job if I spoke out regarding violence in the workplace.
- I fear reprisals from my employer if I come forth and voice my concerns. Everybody has a right to speak up and to voice their concerns. And it's just a shame that we're made to feel that if you speak up, they're going to put an X on your back and target you . . . and you're going to lose your job. But it doesn't have to be that way. If we could all sit down, and talk about it logically, and talk about it in a polite manner, so that we could all get our points across. It would be successful. And it's called respect.
- I think it's unfortunate that I can't talk publicly about having urinals thrown at me, having patients grab you and twist your arm, threaten you, having patients tell you that you're worthless and mean nothing. I don't think it's right that my identity has to be hidden. But I fear I'll be reprimanded. I don't want to lose my job. And that's what the thoughts are surrounding this job. It's not fair. And I'm sure there are many other people who would love to speak out about their experiences but they are too scared. Or too burned out, and saying, "What's the point?" And it's heart-breaking.
- I'm speaking out now, because people are going to get hurt. People are already getting hurt. And it's just going to get worse. It's not going to get any better because they're not listening to anybody about any safety issues that we have. Staff should not be getting barricaded in the rooms. Staff should not be getting hit with chairs. Getting hit with remotes. Getting hit with VCR's. Getting hit with tapes. Getting hit with whatever they can find. I had a patient make a weapon out of a toilet seat!

sk*cope491

I feel I need to speak out.

Enough is enough.



The Ontario Council of Hospital Unions/CUPE
261 Gerrard St. East
Toronto, Ontario
M5A 2G1

Phone: 416.599.0770
Fax: 416.599.3982
Email: admin@ochu.on.ca

OCHU
ONTARIO COUNCIL OF HOSPITAL UNIONS
CUPE