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Healthy Work Environments
Best Practice Guidelines

JUNE 2009

Preventing and Managing Violence in the Workplace

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

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Greetings from Doris Grinspun,

Executive Director Registered Nurses' Association of Ontario

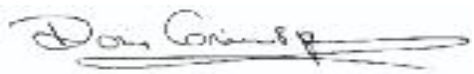
It is with great pleasure that the Registered Nurses' Association of Ontario (RNAO) releases the *Preventing and Managing Violence in the Workplace* Healthy Work Environments Best Practice Guideline. This is one of a series of Best Practice Guidelines (BPGs) on Healthy Work Environments (HWEs) developed by the nursing community to date. The aim of these guidelines is to provide the best available evidence to support the creation of healthy and thriving work environments. These guidelines, when applied, will serve to support the excellence in service that nurses are committed to delivering in their day-to-day practice. The RNAO is delighted to be able to provide this key resource to you.

We offer our endless gratitude to the many individuals and institutions that are making our vision for HWE BPGs a reality: the Government of Ontario, for recognizing the RNAO's ability to lead the program and providing generous funding; Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines (IABPG) Programs, for her expertise and leadership in advancing the production of HWE BPGs; all HWE BPG Team Leaders, and for this BPG in particular, Margaret Keatings and Daina Mueller, for their superb stewardship, commitment and, above all, exquisite expertise. Thanks to Valerie Coubrough, who provided expert coordination and worked intensely to see that this BPG move from concept to reality. A special thanks to the BPG panel – we respect and value your expertise and volunteer work. To all, we could not have done this without you!

The nursing community, which is committed to and passionate about excellence in nursing care and healthy work environments, has provided extensive knowledge and countless hours essential to the creation, evaluation and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementing and evaluating the guidelines, and working toward a culture of evidence-based practice.

Creating healthy work environments is both an individual and collective responsibility. Successful uptake of these guidelines requires a concerted effort by governments, administrators, clinical staff and others, partnering together to create evidence-based practice cultures. We ask that you share this guideline with members of your team. There is much we can learn from one another.

Together, we can ensure that nurses and all other health-care workers contribute to building healthy work environments. This is central to ensuring quality patient care. Let's make health-care providers and the people they serve the real winners in this important effort!



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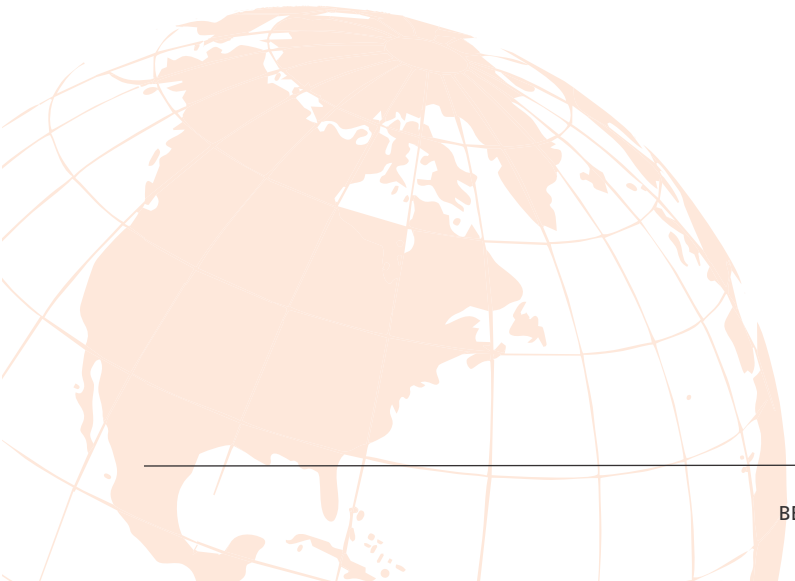
Throughout this document words marked with the letter G can be found in the Appendix A: Glossary of Terms



How to Use this Document

This Healthy Work Environments Best Practice Guideline is an evidence-based document that focuses on preventing and addressing violence against nurses in the workplace.

The guideline contains much valuable information, but is not intended to be read and applied at one time. We recommend that you review and reflect on the document, and implement the guidelines as appropriate for your organization at a particular time. The following approach may be helpful.

1. **Study the Healthy Work Environments Organizing Framework:** The *Preventing and Managing Violence in the Workplace* Best Practice Guideline is built upon the Healthy Work Environments Organizing Framework that was created to enable users to understand the relationships between and among the key factors. Understanding the framework is critical to using the guideline effectively. We suggest that you spend time reading and reflecting upon the framework as a first step.
2. **Identify an area of focus:** Once you have studied the framework, we suggest that you identify an area of focus for yourself, your situation, or your organization. Select an area that you believe needs attention to provide a violence-free, nurse-supportive environment.
3. **Read the recommendations and the summary of research for your area of focus:** For each major element of the model, a number of evidence-based recommendations are offered. The recommendations are statements of what nurses, organizations and systems do, or how they behave in order to provide a violence-free, supportive work environment for nurses. The literature supporting those recommendations is briefly summarized, and we believe that you will find it helpful to read this summary to understand the rationale for the recommendations.
4. **Focus on the recommendations or desired behaviours that seem most appropriate to you and your current situation:** The recommendations contained in this document are not meant to be applied as rules, but rather as tools to assist individuals, organizations and systems to make decisions that work towards providing a violence-free and supportive environment for nurses, recognizing everyone's unique culture, climate and situational challenges. In some cases, there is much information to consider. You may wish to further explore and identify those behaviours that need to be analyzed or strengthened in your situation.
5. **Develop a tentative plan:** Having selected a small number of recommendations and behaviours for attention, consider strategies to successfully implement those you have chosen. Develop a tentative plan for what you might actually do to begin to address your area of focus. If you need more information, you may wish to refer to some of the references cited, or review some of the risk assessment tools identified in Appendix D.
6. **Discuss the plan with others:** Take time to seek input into your plan from people who it might affect or whose engagement will be critical to success, and from trusted advisors, who will give you honest and helpful feedback on the appropriateness of your ideas. This is as important a phase for the development of individual practice skills as it is for the development of an organizational violence prevention and management initiative.
7. **Revise your plan and get started:** It is important that you make adjustments as you proceed with implementation of this guideline. The development of a violence prevention and management process is a life-long quest. Enjoy the journey!

Purpose and Scope

For the purpose of this document, violence in the workplace is defined as a multidimensional phenomenon involving the misuse of power and resulting in physical, psychological or sexual abuse of targets. Perpetrators of violence may not be known to the organization (type I) or may involve patients/clients/family members (type II), present or past staff members (type III) or personal relationships (type IV).[1]

Purpose:

We have developed this best practice guideline to:

- Define and describe violence in the workplace.
- Identify strategies to plan, implement and evaluate outcomes related to recognizing and assessing the risk of violence in the workplace, thereby fostering healthy work environments for nurses and supporting healthy outcomes for patients/clients, organizations and systems.
- Identify individual, organizational and system resources that support prevention, recognition and early detection and effective intervention related to violence in the workplace.
- Identify outcomes related to prevention, recognition, early detection and successful mitigation of violence in the workplace.

Scope:

To recognize, prevent and effectively intervene in violence in the workplace. This guideline addresses:

- Knowledge, competencies and behaviours.
- Educational requirements and strategies.
- Organizational, operational and system policy requirements.
- Implementation strategies and tools.
- Evaluation criteria and tools.
- Future research opportunities.

Target Group:

This guideline is relevant to all nurses in all settings and is intended for:

- Nurses in all roles and settings.
- Interdisciplinary team members.
- Students from all health-care professions.
- Organizational boards and administrators at all levels of the organization and system.
- Policy makers, regulatory bodies and governments.
- Professional organizations, employers and labour groups.
- Educators.
- Researchers.
- Other stakeholders, including patients/clients, family advisory groups, law enforcement/security personnel and the public.

Summary of the Recommendations for Preventing and Managing Violence in the Workplace

The following recommendations are organized using the key concepts of the Healthy Work Environments Framework:

- System recommendations,
- Organizational recommendations, and
- Team/Individual recommendations.

RECOMMENDATIONS	
SYSTEM RECOMMENDATIONS	**1.0 Governments**
	1.1 Governments promote a workplace[1] free from violence by: a. Enacting and enforcing legislation that promotes a violence-free workplace. This would include a review of existing legislation[2] and regulations in consultation with professional associations, regulatory bodies, unions and health service organizations. Such legislation must include mandatory reporting and whistle-blower protection for those who report violence in the workplace. It must also include structural changes that equalize power bases, as this is a key contributor to aggression.[3] Specifically, it must transform legislated Medical Advisory Committees into legislated Interprofessional Advisory Committees that will allow all health-care providers to participate fully in creating a healthy work environment and excellence in patient care. This does not preclude the utilization of discipline-specific professional practice committees to address discipline-specific practice issues. b. Disseminating broadly the resources required to assist with implementation of revised legislation. c. Ensuring adequate funding for staffing, mandatory education and leadership development to prevent, identify and respond to violence in the workplace. d. Role modeling respectful behaviours towards nurses and other health-care professionals and ensuring that they are involved in planning and decision-making processes related to health, safety and wellness issues. e. Developing and monitoring organizational accountability. This would include, but not be limited to, indicators to measure effectiveness of prevention programs, prevalence and incidence of violence in the work setting, as well as fair and consistent responses to the reporting of violence, regardless of the power base of those involved in the violence. f. Reviewing and responding to recommendations from coroners' inquests in keeping with the development of a workplace free of violence.
	1.2 Governments fund, and engage with communities in developing and implementing multisectoral strategies that address the root causes of violence, including the social determinants. These strategies must improve health and strengthen communities.[4]

Notes:

1. In this guideline the term workplace is defined as all service and academic settings.
2. In Ontario this would include, but not be limited to, the *Public Hospital Act*, the *Regulated Health Professions Act, Occupational Health and Safety Act, Workplace Safety and Insurance Act,* and the *Labour Relations Act.*
3. In Ontario this would include transforming the Medical Advisory Committee (MAC) into an Inter-professional Advisory Committee (IPAC). This structure already exists in the Local Health Intergration Networks (LHINs) and serves as the standard for professional structures in all health-care organizations.
4. In Ontario this can be facilitated by the LHINs.

RECOMMENDATIONS	
SYSTEM RECOMMENDATIONS	**2.0 Research**
	2.1 Researchers partner with governments, professional associations, regulatory bodies, unions, health service organizations and educational institutions, to conduct research into workplace violence. The goal is to increase understanding of preventive measures, early identification, occurrences of violence and their impact on staff and staffing, retention and recruitment of nurses and other health-care professionals, and organizational performance.
	2.2 Interprofessional researchers study the: a. Prevalence and incidence of violence in workplaces throughout all types of organizational settings and in all sectors. b. Nature of mitigating factors influencing violence in the workplace including incivility experienced by nurses and other health-care workers, nursing students and educators in academic and clinical practice settings. c. Range of impacts of bullying and violence in the workplace (including health effects, career, financial and professional effects) on targeted nurses and other health-care workers, and on patient/client, organizational and system outcomes, including quality of care. d. Existence and effectiveness of current management philosophies and practices to assess risk, prevent and manage violence in the workplace. e. Efficacy of programs to assess the nature and prevalence of violence and prevent it, evaluating the effectiveness of existing and future workplace violence training and education programs.
	2.3 Researchers develop, implement and evaluate research on the conceptual model constructed for these guidelines to assess its fit with the concept of workplace violence.
	3.0 Accreditation
	3.1 Accreditation bodies develop and implement standards in the accreditation process that support violence-free workplaces and incorporate recommendations contained in this guideline into their standards.
	4.0 Education
	4.1 Education for all health-care professionals includes: a. Formal and informal opportunities for discipline-specific and interprofessional students to develop and demonstrate the ability to recognize, prevent and manage violence in the workplace. b. Opportunities for students to learn how to protect themselves from violence in the workplace. c. Appropriate communication strategies for responding to conflict and/or "escalating aggression" in the workplace from patients, peers and other health-care professionals, supervisors and faculty. d. Learning related to how, and when, to use formal reporting methods for addressing violence in the workplace. e. Supporting students in recognizing the impact of violence in the workplace on health, career and life, and encouragement to seek individual, organizational and systemic solutions. f. Opportunities for participants to examine the workplace culture using critical social theory perspectives.

RECOMMENDATIONS	
SYSTEM RECOMMENDATIONS	g. Ensuring that students are informed and adhere to academic and service health and safety policies and procedures related to the prevention and management of violence in clinical placements.
	4.2 Education programs and educators for all health-care professionals: a. Recognize that intended and unintended forms of incivility, aggression and violence enacted in academic and clinical settings can serve to reproduce and escalate violent behaviours and practices between and among all health-care professionals in academic and health-care organizations. b. Review and respond to recommendations from coroners' inquests to ensure that programs are in keeping with the development of a workplace free of violence.
	4.3 Academic settings role model a violence-free environment and culture by fully adhering to their organizational policies, procedures and practices, and augmenting any gaps in those with recommendations included in this guideline.
	5.0 Professional, Regulatory and Union Bodies
	5.1 Professional, regulatory and union bodies for health-care professionals: a. Serve as role models through the creation of safe, respectful and violence-free environments within their workplace's staff, board of directors, committees and volunteers. b. Establish outreach programs that address violence in the workplace. c. Reflect the importance of safe, respectful, violence-free working environments in all applicable policies, standards, guidelines and educational materials developed by the organizations. d. Develop and collaborate with others to communicate common education and advocacy messages, that advance violence-free working environments. e. Educate health-care professionals and the public regarding violence in the workplace, including systemic, organizational and individual prevention, early detection and management. f. Review and respond to recommendations from coroners' inquests to ensure that standards and educational programs are in keeping with the development of a workplace free of violence.
ORGANIZATIONAL RECOMMENDATIONS	**6.0 Organizational Recommendations**
	6.1 Service and academic organizations promote and support a workplace free of violence by: a. Ensuring that the safety of staff, physicians, volunteers and students is aligned with the organization's values and is a strategic priority which is fully integrated into corporate and service specific goals. b. Developing and implementing a violence prevention policy and program that addresses all forms of violence in the workplace. The policy and program adopts clear codes of behaviour that guide all internal and external stakeholders in addressing all forms of violence or potential violence and institute mandatory reporting as well as whistle-blower protection for those who report incidents of actual or potential violence. c. Identifying situations where there is imbalance of power, such as employer/employee, physician/nurse, student/staff and ensuring structural changes to equalize power bases, as this is a key contributor to aggression.

	RECOMMENDATIONS
ORGANIZATIONAL RECOMMENDATIONS	d. Ensuring structures and processes are in place that enable all health-care professionals to have a shared role in organizational and clinical decision making. e. Adopt patient/family/relationship-centred care models and introduce strategies to promote respect among all members of the health-care team, patients/clients and other stakeholders. f. Identifying strategies to recognize and respond to employees' personal situations that may expose themselves, and other co-workers to violence danger. g. Ensuring that any disruptive behaviour by employees, physicians, volunteers and students is addressed in a timely manner through performance improvement/disciplinary processes that include competencies related to promoting a violence-free workplace. h. Reviewing and responding to recommendations from coroners' inquests in keeping with the development of a workplace free of violence.
	6.2 Service and academic organizations introduce the appropriate controls to establish a comprehensive prevention program and continuously monitor the progress towards a violence-free workplace by: a. Conducting ongoing risk/hazard assessments that include employees, physicians, volunteers and students input to ascertain the risk of potential and actual violence in the workplace including monitoring incidents of actual and potential violence so that specific strategies for ongoing improvement can be identified. b. Ensuring that appropriate environmental, administrative, work/care and safety practices are implemented to promote a violence-free environment.
	6.3 Service and academic organizations ensure all employees, physicians, volunteers and students have the knowledge and competencies related to promoting a violence-free, healthy work environment by: a. Providing resources for ongoing mandatory education. b. Educating all administrators, clinicians in all roles, and support staff on how to respond to and manage violence in the workplace, including implementation and evaluation procedures. c. Creating and delivering a clear communication strategy to ensure that all persons who have a relationship with the organization are aware of the violence-free program including the processes for mandatory reporting and responding to incidents of violence in the workplace.
	6.4 Service and academic organizations develop and implement a process to evaluate the violence in the workplace prevention program by: a. Developing and monitoring organizational accountability. This would include, but not be limited to, indicators to measure effectiveness of prevention programs, prevalence and incidence of violence, as well as fair and consistent response to reported violence regardless of the power base of those involved in the violence.

	RECOMMENDATIONS
ORGANIZATIONAL RECOMMENDATIONS	6.5 Service and academic organizations create a strategy for immediate and organized response to direct threats of violence by simultaneously: a. Ensuring safety/security measures are immediately implemented. This includes contacting police when appropriate. b. Immediately investigating all reports of direct threat of violence. c. Securing timely response measures, corrective action, assistance and support to target(s), and appropriate follow up. d. Making workplace accommodations such as, but not limited to, changing staff schedules and/or making work/study re-assignments as necessary.
TEAM/INDIVIDUAL RECOMMENDATIONS	**7.0 Team/Individual Recommendations** 7.1 All employees, physicians, volunteers and students: a. Acquire the knowledge and competencies to prevent, identify, and respond to potential violence. b. Engage in self-reflective practice and examine how one's behaviour impacts others and how the behaviour of others impacts them. c Practice and collaborate with team members in a manner that fosters respect, trust and prevents violence. This includes refraining from as actions such as gossiping, bullying, harassment, socially isolating others, pushing, throwing elements, or any other behaviours that constitute aggression. d. Contribute to the development of organizational strategies to prevent, identify and respond to violence. e. Fully adhere to organizational policies, procedures and practices related to preventing, identifying and responding to workplace violence. f. Follow organizational processes related to mandatory reporting, seeking support and providing support to others when potentially violent situations are identified or violent situations occur.

Sources and Types of Evidence on Preventing Violence in the Workplace

Sources of Evidence

The search for evidence revealed experimental, quasi-experimental, descriptive and qualitative studies. Sources included:

- A systematic review of the literature on violence was conducted (see Appendix C).
- Supplemental literature was searched by panel members.

Types of Evidence

Current practice in creating best practice guidelines involves identifying the strength of the supporting evidence.[1] The prevailing systems of grading evidence identify systematic reviews of randomized controlled trials (RCTs) as the "gold standard" for evidence with other methods ranked lower.[ii] However, not all questions of interest are amenable to RCT methods, particularly where the subjects cannot be randomized or the variables of interest are pre-existing or difficult to isolate. This is particularly true of behavioural and organizational research, in which controlled studies are difficult to design due to continuously changing organizational structures and processes. Moreover, since health-care professionals are concerned with more than cause-and-effect relationships and recognize a wide range of approaches to generate knowledge for practice, we have adapted the traditional levels of evidence used by the Cochrane Collaboration[iii] and the Scottish Intercollegiate Guidelines Network to identify the type of evidence contained in this guideline.[4]

Types of Evidence System

Type of Evidence	Description of Evidence
A	Evidence obtained from controlled studies, meta-analyses[G]
A1	Systematic review[G]
B	Evidence obtained from descriptive correlational studies[G]
C	Evidence obtained from qualitative research[G]
D	Evidence obtained from expert opinion[G]
D1	Integrative reviews[G]
D2	Critical reviews[G]

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The RNAO would also like to acknowledge Joan Almost, RN, MScN, Doctoral Candidate, Research Assistant for her contribution to the quality appraisal of the literature and preparation of evidence tables.

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Background to the Healthy Work Environments Best Practice Guidelines Project

In July of 2003 the Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, (MOHLTC), commenced the development of evidence-based best practice guidelines in order to create healthy work environments[G] for nurses.[G] Just as with clinical decision-making, it is important that those focusing on creating healthy work environments make decisions based on the best evidence possible.

The Healthy Work Environments Best Practice Guidelines[G] Project is a response to priority needs identified by the Joint Provincial Nursing Committee (JPNC) and the Canadian Nursing Advisory Committee.[6] The idea of developing and widely distributing a healthy work environment guide was first proposed in *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario*[7] submitted to MOHLTC in 2000 and approved by JPNC.

Health-care systems are under mounting pressure to control costs and increase productivity while responding to increasing demands from growing and aging populations, advancing technology and more sophisticated consumerism. In Canada, health-care reform is currently focused on the primary goals identified in the Federal/Provincial/Territorial First Ministers' Agreement 2000,[8] and the Health Accords of 2003[9] and 2004:[10]

- the provision of timely access to health services on the basis of need;
- high-quality, effective, patient/client-centred and safe health services; and
- a sustainable and affordable health-care system.

Nurses are a vital component in achieving these goals. A sufficient supply of nurses is central to sustain affordable access to safe, timely health care. Achievement of healthy work environments for nurses is critical to the safety, recruitment and retention of nurses.

Numerous reports and articles have documented the challenges in recruiting and retaining a healthy nursing workforce.[7,11-15] Some have suggested that the basis for the current nursing shortage is the result of unhealthy work environments.[16-19] Strategies that enhance the workplaces of nurses are required to repair the damage left from a decade of relentless restructuring and downsizing.

There is a growing understanding of the relationship between nurses' work environments, patient/client outcomes and organizational and system performance.[20-22] A number of studies have shown strong links between nurse staffing and adverse patient/client outcomes.[23-33] Evidence shows that healthy work environments yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational health-care costs,[34] and costs arising from adverse patient/client outcomes.[35]

Achievement of healthy work environments for nurses requires transformational change, with "interventions that target underlying workplace and organizational factors".[36] It is with this intention that we have developed these guidelines. We believe that full implementation will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. It is anticipated that a focus on creating healthy work environments will benefit not only nurses but other members of the health-care team. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation.

The Six Foundational Healthy Work Environments Best Practice Guidelines

1. Collaborative Practice Among Nursing Teams
2. Developing and Sustaining Effective Staffing and Workload Practices
3. Developing and Sustaining Nursing Leadership
4. Embracing Cultural Diversity in Health Care: Developing Cultural Competence
5. Professionalism in Nursing
6. Workplace Health, Safety and Well-being of the Nurse

A healthy work environment is…
...a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance, and societal outcomes.

Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

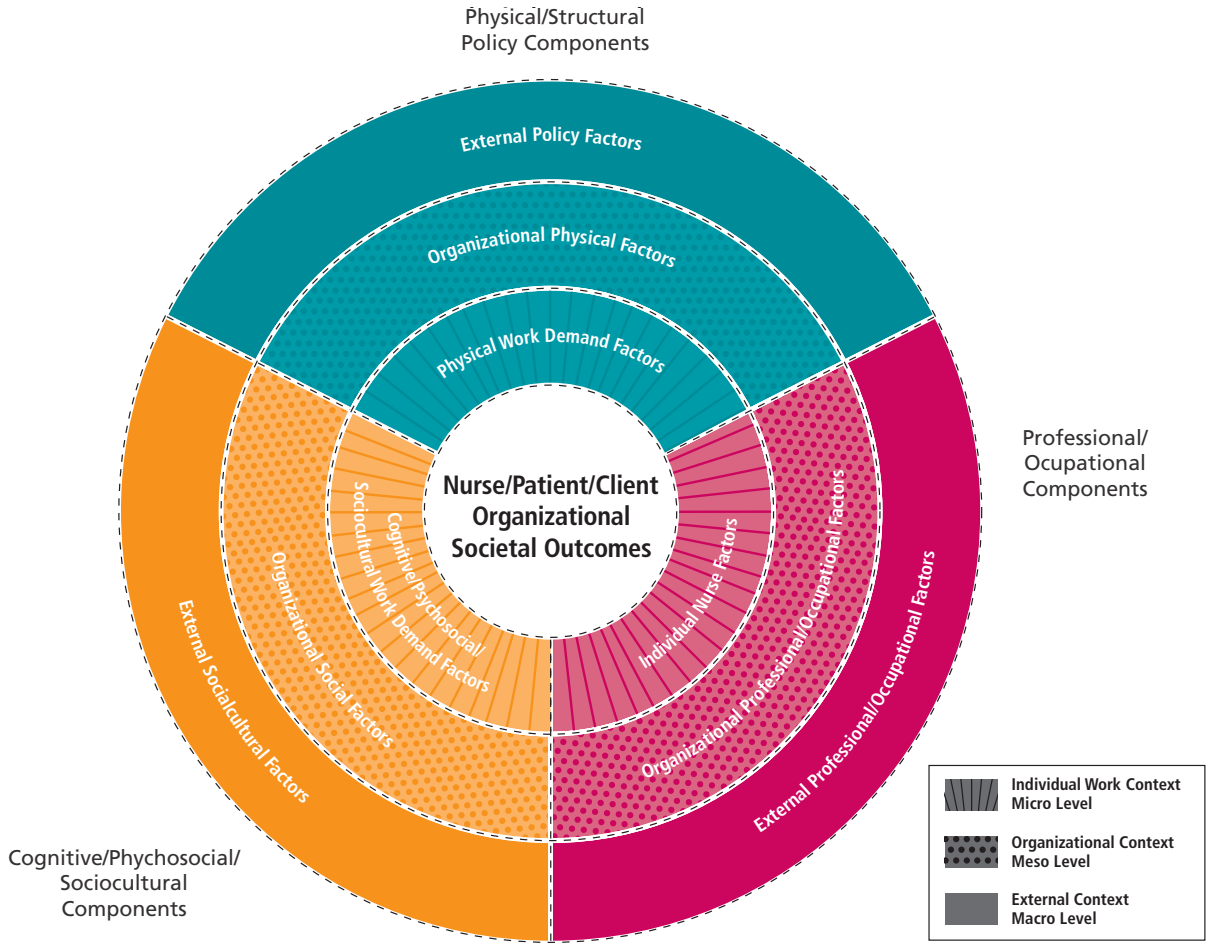

Figure 1 Conceptual Model for Healthy Work Environment for Nurses: Components, Factors and Outcomes [i-iii]

A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships within components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes.

The Comprehensive Conceptual Model for Healthy Work Environments for Nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organizational (meso level) and external (macro level) system determinants, as shown above in the three outer circles in Figure 1. At the core of the circles are the expected beneficiaries of healthy work environments for nurses – nurses themselves, patients, organizations and systems, communities and society as a whole.[iv] The lines within the model are dotted to indicate the synergistic interactions among all levels and components of the model.

The model suggests that the individual's functioning is mediated and influenced by interactions between the individual and her/his environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors, but also influence the system itself.[v,vi]

The assumptions underlying the model are as follows:

- healthy work environments are essential for quality, safe patient/client care;
- the model is applicable to all practice settings and all domains of nursing;
- individual, organizational and external system level factors are the determinants of healthy work environments for nurses;
- factors at all three levels affect the health and well-being of nurses, quality patient/client outcomes, organizational and system performance and societal outcomes, either individually or through synergistic interactions;
- at each level, there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- the professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

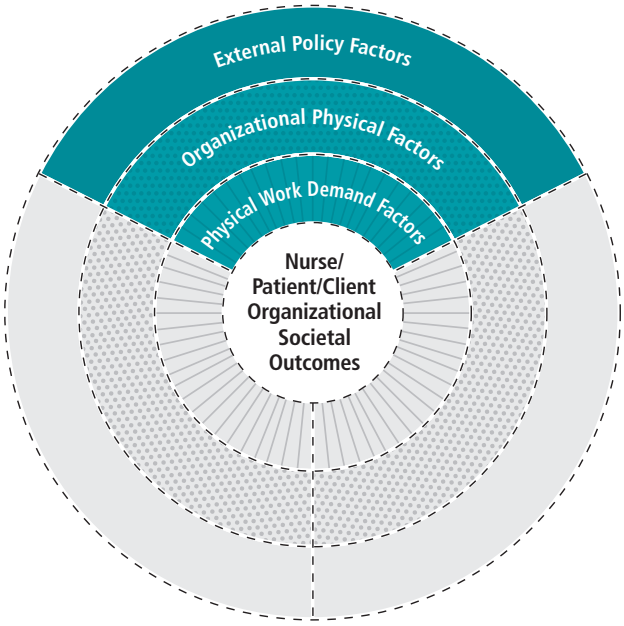

Figure 1A Physical/Structural Policy Components

Physical/Structural Policy Components

- At the individual level, the Physical Work Demand Factors include the requirements of the work that necessitate physical capabilities and effort on the part of the individual.[vii] Included among these factors are workload, changing schedules and shifts, heavy lifting, exposure to hazardous and infectious substances, and threats to personal safety.
- At the organizational level, the Organizational Physical Factors include the physical characteristics and the physical environment of the organization and also the organizational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible scheduling and self-scheduling, access to functioning lifting equipment, occupational health and safety polices, and security personnel.
- At the system or external level, the External Policy Factors include health-care delivery models, funding, and legislative, trade, economic and political frameworks (e.g. migration policies, health-care system reform) external to the organization.

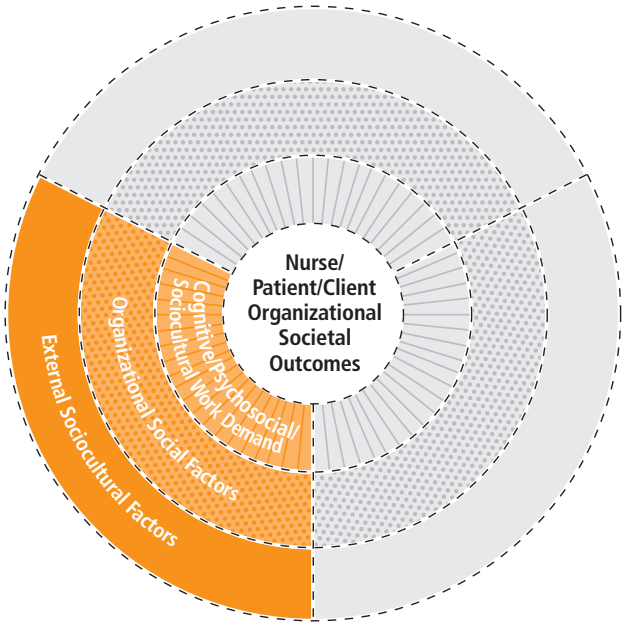

Figure 1B Cognitive/Psychosocial/Sociocultural Components

Cognitive/Psychosocial/Sociocultural Components

- At the individual level, the Cognitive and Psychosocial Work Demand Factors include the requirements of the work that necessitate cognitive, psychological and social capabilities (e.g. clinical knowledge, effective coping skills, communication skills) on the part of the individual.[vii] Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity and role strain.
- At the organizational level, the Organizational Social Factors are related to organizational climate, culture, and values. Included among these factors are organizational stability, communication practices and structures, labour/management relations and a culture of continuous learning and support.
- At the system level, the External Sociocultural Factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics – all of which influence how organizations and individuals operate.

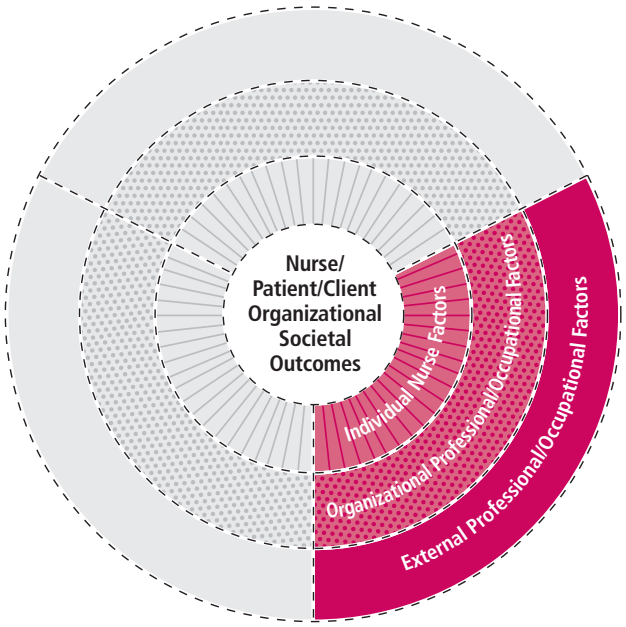

Figure 1C Physical/Occupational Components

Physical/Occupational Components

- At the individual level, the Individual Nurse Factors include the personal attributes and/or acquired skills and knowledge of the nurse which determine how she/he responds to the physical, cognitive and psychosocial demands of work.[vii] Included among these factors are commitment to patient/client care, the organization and the profession; personal values and ethics; reflective practice; resilience, adaptability and self confidence; and family/life balance.
- At the organizational level, the Organizational Professional/Occupational Factors are characteristic of the nature and role of the profession/ occupation. Included among these factors are the scope of practice, level of autonomy and control over practice, and intra-disciplinary relationships.
- At the system or external level, the External Professional/ Occupational Factors include policies and regulations at the provincial/ territorial, national and international level which influence health and social policy and role socializations within and across disciplines and domains.

BACKGROUND

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Background Context of the Guideline on Preventing and Managing Violence in the Workplace

Violence in the workplace is believed to be on the rise,[37-40] despite evidence of significant underreporting.[41-45] Sustained exposure to violence in the workplace, including aggression, abuse, and bullying can have serious physical and psychological consequences,[44,46-50] causing some nurses to consider leaving the profession.[44,45,51,52] Workplace violence, including disruptive physician behaviour, also results in decreased patient safety.[53-57] Clearly, violence against nurses is an important issue among nurses, their patients and the nursing profession at large. This best practice guideline on preventing violence in the workplace provides clear and courageous recommendations for realistic actions that can be undertaken in health and community-sector workplaces by governments, institutional boards and administrations, as well as all front-line health-care providers, to prevent and manage wide-ranging forms of violence.

What is violence in the workplace? The RNAO position paper on violence against nurses and nursing students in the workplace[58] defines workplace violence as "an incident of aggression that is physical, sexual, verbal, emotional or psychological that occurs when nurses are abused, threatened or assaulted in circumstances related to their work".[59]

As with other forms of abuse and aggression, violence in the workplace involves misuse of power and control.[47,60,61] Violence in the workplace includes "incidents where staff are abused, threatened, bullied, or assaulted in circumstances related to their work, including commuting to and from work, involving explicit or implicit challenges to their safety, well-being or health,"[59] or in the course of their employment. Section 13(1) of the *Workplace Safety Insurance Act* (WSI), states that a worker who sustains a personal injury/illness by an accident arising out of and in the course of his or her employment, is entitled to benefits. Violence in the workplace may take the forms of physical, psychological or sexual abuse, harassment, mobbing, bullying, or aggression. It may involve action or withholding action. It may be done unintentionally or intentionally.[62] It often involves interactions between people in different roles and power relationships.[60]

Three forms of violence have been defined by the Joint Program on Workplace Violence in the Health Sector.[63] Physical violence involves actions using force against another, including beating, stabbing, shooting, raping, pushing, hitting and any other forms of physical aggression/assault. Sexual violence includes verbal or physical behaviours based on gender and/or sexuality. Psychological violence involves verbal or physical threats, intimidation, or demeaning behaviours such as being followed, insulted, sworn or shouted at, criticized, made to feel bad or guilty, and includes passive aggressive approaches and acts of neglect or failure to acknowledge contributions of others. "Although a single incident can suffice, psychological violence often consists of repeated, unwelcome, unreciprocated and imposed-upon action which may have devastating effects."[59] These actions may seem relatively minor in isolation, but cumulatively they can become very serious. Psychological violence is only now being accorded priority as a workplace concern. Each of these forms of violence can result in harm to physical, mental, spiritual, or social development whether or not they are intentional.

Perpetrators of violence in the workplace have been classified into four types:[64]

- Type I (Criminal Intent): The perpetrator has no relationship to the workplace.
- Type II (Client or Customer): The perpetrator is a client at the workplace who becomes violent or aggressive toward a staff member or another client.

- Type III (Worker-to-Worker): The perpetrator is a staff member or past staff member of the workplace, including managers, workers, physicians, contracted staff or service workers and volunteers.
- Type IV (Personal Relationship): The perpetrator is a person with a relationship to a staff member who becomes violent or aggressive toward that staff member in the workplace.

Recent research on workplace aggression in the general population reports that "harm-doing behaviour" or abusive bullying in the workplace is more likely to be verbal, to be passive rather than direct, and to have a "top down element."[37,38,49,52,65,66] Such violence or abuse commonly features "persistence and repetition; offensive, unsafe, unwanted, or intimidating behaviours; and abuse of power or control in the workplace."[47] Understandings from this discourse inform the recommendations in this document. Ultimately, this best practice guideline to address violence in the workplace is intended to help create healthy workplaces where patterns of violence, in all forms, are reduced and managed more effectively.

Intimate partner violence experienced by employees that occurs either within or outside the workplace can also be a contributing factor to the incidence of violence in the workplace. Research conducted on the prevalence of violence against women reports that women from professional backgrounds have experienced violence at some time in their lives. Since the majority of individuals employed as nurses are women, this finding suggests a probability that nurses also experience intimate partner violence. In a survey of emergency room (ER) nurses, Ellis[67] found that 57.5% of the respondents had personal experience with violence against women, with 25% of respondents reporting they experienced the violence themselves.[68] Measures outlined in this guideline will also serve to protect employees from incidences of violence in the workplace that result from intimate partner violence.

In the last decade, studies have revealed persistent, high levels of violence in the workplace internationally.[12,46,50,52] In Ontario, the health/community care sector has the highest rate of lost time injuries (LTI) due to violence in the workplace, compared with any other sector in the province. Health care occupies 34% of the LTIs, followed by the municipal sector (fire and police) at 25%,and the education sector at 12%. In the health and community sector, hospitals have the highest LTI rate at 32%, followed by nursing homes at 25% and group homes at 20%.[64] From this rapidly expanding discourse, we know that nurses are at higher risk of violence in the workplace than other health-care providers[46,69] and other workers,[61] particularly in relation to violence from patients/clients or their families.[70] Nurses working alone, or in home health care or community settings, may be at even greater risk. Violence against nurses is also known to come from other health-care professionals[71] and nurses are known to perpetrate violence against patients/clients. While nurse to patient/client violence is not within the scope of this guideline, addressing patterns of violence against nurses will in our view diminish violence against patients/clients.

The impact on people who are bullied includes a wide range of negative health effects, including burnout,[72] diminished self-esteem,[45,73] long-term fatigue,[74] distress and sleep disturbances,[75,76] depression and other psychological symptoms,[77-79] social isolation,[80] increased sickness,[81,82] and physical injury including death.[83] Higher levels of physical and psychological stress have been associated with bullying related to sexism, discrimination and organizational unresponsiveness to sexism.[84] In addition to the impact on targets, significant organizational costs of violence in the workplace include increased costs for sick time and health-care plans,[52,75,76,85,86] increased absenteeism, lower productivity, stress-related illness and high turnover,[87] decreased capacity to offer effective nursing care,[70] increased costs for recruitment and retention,[73,76,78,79] and diminished sense of professional competence with potential to compromise patient/client health outcomes.[61] From a risk management perspective, this guideline provides structural processes to identify and manage risks to patients/clients, families, nurses, health-care professionals and other staff, with optimal physical and psychological outcomes for targets of violent episodes.

While conflict is not the same as violence in the workplace, unresolved conflict may escalate into violence and may influence nurses' intent to remain in the workplace.[90,91] Difficulty retaining nurses has been associated with conflict in the workplace,[92] and lack of support for and satisfaction with work.[93] Commonly, nurses report feeling unsupported in their practice,[39,94,95] and not prepared in their undergraduate programs to cope with aggression from fellow professionals such as peers, faculty and preceptors.[52,61,96] Aiken et al.'s study of 43,000 nurses across five countries revealed that less than half of the nurses surveyed were satisfied with organizational responses to their concerns or had opportunities to participate in decision-making, or felt that their contribution to patient care was acknowledged.[97] Stevens[89] calls attention to how bullying has been embedded in the nursing profession and how managerial cultures have dismissed bullying as a problem. Her case study-based research illuminates how a "bullying culture" can be successfully challenged, an approach this guideline takes into account in its recommendations.

From the looming evidence of violence against nurses in the workplace – much of which is underreported and silenced – what can nurses in all roles and sectors do to help break the cycle of violence, which is rampant and reproduced in workplaces? How can we create respectful and caring cultures within our practice settings in view of growing evidence of abusive and oppressive workplaces that demoralize and denigrate nurses who love nursing yet loathe their workplace? Most importantly, how can we move solidly beyond our compelling rhetoric supporting "zero tolerance"[63,98] into actions that prevent and mitigate violence toward nurses?

Multiple challenges related to violence – some of which are unforeseen – arise in workplaces in which nurses work on a daily basis, and call for evidence-based action on the part of every health-care professional. Being attuned and attentive to this painful and destructive element of the workplace is essential for the recruitment and retention of productive nurses who feel valued and who, with confidence, can address patient/client-nurse, nurse-nurse and other-nurse violence when it erupts, with personal grace and professional competence. This guideline provides solid recommendations that translate core nursing values into action. While this document has separated these guidelines into the categories of individual, organizational and system guidelines, it must be stressed that they are all interconnected and interdependent, and that implementation of guidelines from all areas are necessary to effect change. This guideline constitutes part of the package of six HWE guidelines needing implementation. Although the ultimate goal of this BPG is to foster violence-free work environments, we acknowledge that this is a multidimensional problem and that there is no single solution to preventing workplace aggression and violence.[99] It is also recognized that in many organizations, strong leadership is required to implement these guidelines and shift the culture to one that supports a workplace free of violence.

System Recommendations

The following recommendations are organized using the Healthy Work Environments framework, and reflect physical/structural, cognitive, psychological, social, cultural, professional and occupational components of preventing violence in the workplace that must be addressed at the external/systems level to ensure best practice. The external/systems factors that are identified in the various components include:

Physical/Structural components:

- Health-care delivery models
- Funding
- Legislation (e.g. health system reform)

Cognitive/Psychological/Social/Cultural components:

- Consumer expectations (e.g. changing care preferences)
- Changing roles of family
- Diversity of population and health-care providers
- Changing professional roles

Professional/Occupational components

- Policies and regulations at the provincial/territorial, national and international levels that influence how organizations and individuals behave with respect to managing and preventing violence against nurses in the workplace
- Competencies and standards of practice that influence the behaviour of team members
- Role socialization within and across disciplines

SYSTEM RECOMMENDATIONS	
1.0	**Governments**
	1.1 Governments promote a workplace free from violence by: a. Enacting and enforcing legislation that promotes a violence-free workplace. This would include a review of existing legislation[2] and regulations in consultation with professional associations, regulatory bodies, unions and health service organizations. Such legislation must include mandatory reporting and whistle-blower protection for those who report violence in the workplace. It must also include structural changes that equalize power bases, as this is a key contributor to aggression[3]. Specifically, it must transform legislated Medical Advisory Committees into legislated Interprofessional Advisory Committees that will allow all health-care providers to participate fully in creating a healthy work environment and excellence in patient care. This does not preclude the utilization of discipline-specific professional practice committees to address discipline-specific practice issues. b. Disseminating broadly the resources required to assist with implementation of revised legislation. c. Ensuring adequate funding for staffing, mandatory education and leadership development to prevent, identify and respond to violence in the workplace. d. Role modeling respectful behaviours towards nurses and other health-care professionals and ensuring that they are involved in planning and decision-making processes related to health, safety and wellness issues.

1.0	Governments continued
	e. Developing and monitoring organizational accountability. This would include, but not be limited to, indicators to measure effectiveness of prevention programs, prevalence and incidence of violence in the work setting, as well as fair and consistent responses to the reporting of violence, regardless of the power base of those involved in the violence. f. Reviewing and responding to recommendations from coroners' inquests in keeping with the development of a workplace free of violence.
	1.2 Governments fund, and engage with communities in developing and implementing multisectoral strategies that address the root causes of violence, including the social determinants. These strategies must improve health and strengthen communities.[4]

Discussion of Evidence[a]

It is now recognized that an integrated organizational perspective is required to reduce violence in the workplace, as with the management of any other occupational health hazard.[99] There is no single factor to explain violence. System level and integrated approaches including government action at various levels to fund sufficient resources, nursing education, leadership and changes to legislation, are needed to effect change.[99,100] At this time, it is important to acknowledge that the Ontario Ministry of Labour has distributed a Consultation Paper on Workplace Violence and solicited input into whether the current *Occupational Health and Safety Act* and its regulations require changes or enhancements to further prevent workplace violence.[101] Studies have shown that poor working conditions and staffing levels are key contributors to the violence experienced by nurses.[102-104] Governments have the responsibility to ensure that sufficient economic and human resources are in place within the work environment to develop, implement and evaluate programs that focus on changing this environment.[105,106] Human resources include the development of nursing leadership as a key component to successful change within organizations.[50] Additional funding should be made available and tied to improvements in the protection afforded to staff such as modifications to the physical environment.[104,106]

Effective prevention programs regarding violence in the workplace require that education, protocols and guidelines be established at various levels within organizations and that nurses be provided opportunities to shape these strategies.[99,106-109] Recent studies have demonstrated that a significant proportion of domestic violence experienced by women is transferred into the workplace.[110] This is a particularly significant finding for nursing. A jury in the inquest into the deaths of nurse Lori Dupont and Dr. Marc Daniel further recommended that the Health and Safety Association (HSA) through consultation with the Ontario Women's Directorate (OWD) develop and disseminate educational materials to all workplaces to support staff so that domestic violence, harassment and abuse education can be provided. Coroner's inquest reports and recommendations related to violence in the workplace need to be reviewed and appropriate recommendations implemented if a workplace free of violence is to be achieved.

Workplace violence is a very complex issue. In order to be successful at dealing with and preventing violence in the workplace, strategies that address the root causes of violence, which include the social determinants of health, must be developed and implemented. Communities and nurses should be key participants in the development and implementation of multisectoral strategies to address this issue.

[a]Type of Evidence – There is B, C, D type of evidence to support this recommendation.

In order for governments to ensure that organizations are able to implement change, a review of existing legislation (e.g. the *Public Hospitals Act* (PHA), Ontario *Occupational Health and Safety Act* (OHSA) and regulations to ensure stakeholder safety should be conducted in consultation with provincial organizations, associations and unions. For example recommended changes to the Ontario PHA should include:

- Amendment of the PHA to explicitly recognize the application of the OOHSA and the Ontario Human Rights Code (OHRC) to physicians with privileges at public hospitals, when the behaviour of physicians negatively impacts the staff of the hospital.
- Ensuring that patient and staff safety is the most important factor, and which would not be superseded by a physician's right to practice.
- Ensuring that processes are implemented that enable hospitals to exercise the appropriate degree of authority over physician's working in their institutions.
- Review of the parameters for the approval of physician credentialing applications for reappointments to medical staff.
- The requirement of mandatory reporting to the College of Physicians and Surgeons of Ontario (CPSO) in section 33 of the PHA should be reconciled with the reporting obligation in section 85.5 of the *Regulated Health Professions Act* (RHPA) and should include reporting for physicians who have been placed on probationary status and/or have had their privileges restricted or reduced during an investigation.[111]
- Transformation of legislated Medical Advisory Committees into legislated Interprofessional Advisory Committees.
- Include whistle blower protection for those who report violence in the workplace.

Inequality of status is reported to result in violence toward those of lesser status.[53,112-116] In order to promote respect for the contributions of all health-care professionals, interprofessional advisory committees (IPACs) should be legislated to replace Medical Advisory Committees (MACs). IPACs would serve to ensure that all professional groups have equal access and input into key decision-making processes that affect the health and well-being of patients, staff and organizations. IPACs would not preclude the existence of discipline-specific committees to deal with discipline-specific issues.

Governments should also ensure that they role model equality by eliminating hierarchies in the health ministry, which diminish the role of nurses or place them in a subservient role. [53,112-118]

The Ontario Ministry of Labour (MOL) should conduct a review of the OHSA to examine the feasibility of including domestic violence, abuse and harassment factors warranting investigation and appropriate action by the Ministry of Labour when the safety and well-being of staff is an issue. The review should consider whether safety from emotional or psychological harm, rather than merely physical harm, ought to be part of the mandate of the Ministry.

Many sectors and agencies are required to participate in prevention activities, with evaluation an integral part of all programs (including monitoring rates of violence in public places e.g. workplaces) and take steps to address problems that might lead to violence.[106] In many provinces, there are systems in place to collect data related to workplace violence. These systems includes staff surveys and the extent of workplace injuries reported through occupational health and safety organizations and workplace safety and insurance boards. The data collected must be reviewed and strategies developed to address each issue. Monitoring of this information and addressing issues that arise should be compulsory.[99]

2.0	Research
	2.1 Researchers partner with governments, professional associations, regulatory bodies, unions, health service organizations and educational institutions, to conduct research into workplace violence. The goal is to increase understanding of preventive measures, early identification, occurrences of violence and their impact on staff and staffing, retention and recruitment of nurses and other health-care professionals, and organizational performance.
	2.2 Interprofessional researchers study the: a. Prevalence and incidence of violence in workplaces throughout all types of organizational settings and in all sectors. b. Nature of mitigating factors influencing violence in the workplace including incivility experienced by nurses and other health-care workers, nursing students and educators in academic and clinical practice settings. c. Range of impacts of bullying and violence in the workplace (including health effects, career, financial and professional effects) on targeted nurses and other health-care workers, and on patient/client, organizational and system outcomes, including quality of care. d. Existence and effectiveness of current management philosophies and practices to assess risk, prevent and manage violence in the workplace. e. Efficacy of programs to assess the nature and prevalence of violence and prevent it, evaluating the effectiveness of existing and future workplace violence training and education programs.
	2.3 Researchers develop, implement and evaluate research on the conceptual model constructed for these guidelines to assess its fit with the concept of workplace violence.

Discussion of Evidence[b]

Interprofessional researchers must partner with governments, educational and health-care professional organizations, and health service organizations to design research that will increase understanding of the impact of violence in the workplace on health-care providers. From an institutional perspective, impacts of interest are those that affect staffing, recruitment and retention of nurses. From the perspective of individuals who are touched by violence directly or indirectly, there is a wide range of personal and career consequences such as health effects, career, financial and professional effects,[105,119-122] all of which can result in long-term consequences of violence. Other complex impacts of interest affect organizations in areas such as orientation, productivity and human resource planning, including organizational and system outcomes such as quality of care.[44,47,123-126]

"Violence and aggression in the health-care setting are on the increase,"[127] and nurses are disproportionately at risk of experiencing violence compared with other health-care providers or other occupational groups sectors.[127] Evidence reveals that violence and aggression in health care may originate from patients/clients and their families, or from colleagues and other health-care workers, and that sustained exposure to violence can have physical and psychological consequences.[46,50] According to Runyan,[128] "violence against workers may also result in disputes among coworkers or from partner violence that spills into the work environment." Despite the burgeoning research on violence in the workplace, challenges persist in defining violence in the workplace because of the plethora of constructs employed –

[b]Type of Evidence – There is B and C type of evidence to support this recommendation.

such as abuse, aggression, bullying, harassment and hostility – to capture violence in the workplace. Research on violence in the workplace is complicated further by the breadth of the health-care system and persistent underreporting of violent incidents.[127] Failure to report violence has been attributed to the absence of reporting channels, fear of being blamed for perceived mismanagment of a patient-family situation, acceptance that violence is simply part of the job, and the common belief that no action to manage the violent episode will be taken. Additionally, Hickling[129] points out that, while some research on violence in the workplace has raised awareness of the problem in the work environment of nurses on a multiple fronts, employment of words such as "harassment" and "bullying" are value-laden, leading to potential biases in the research process[127] and a murky path to uncovering viable actions to address violence in the workplace.

It is timely to study the nature, prevalence and incidence of bullying or violence in the workplace occurring across the whole spectrum of nursing workplaces.[130,131] Nurses work in a wide variety of settings, ranging from institutional to independent environments. For example, in many settings outside hospitals, very little is known about the incidence and specific impacts of violence experienced by workers.[130,131] To further understand the scope and impact of violence in the workplace experienced by nurses, research that takes the organizational and situational context in account is urgently needed. As Randle[122] argued, "the context of where we work will influence whether bullying exists and is allowed to flourish. It is clear that the values and norms of the workplace influence how bullying is defined, how situations are interpreted, and whether bullying is recognized as a problem."

In the last decade, researchers have reported on faculty and nursing student accounts indicating a rise of uncivil behaviour in student-teacher relations.[132] These authors defined incivility as a "speech or action that is disrespectful or rude and ranges from insulting remarks and verbal abuse to explosive, violent behaviour." As 70% of nursing faculty and student participants perceived incivility as being a "moderate or serious problem"[132] in nursing education, the need for funded research programs to explore the mitigating factors (i.e. situational, contextual, systemic) that allow incivility to flourish is urgently needed. Myrick et al's Canadian research study,[133] an exploration of conflict within the context of "field [clinical] teaching" with prospective nurses, teachers, social workers and doctors, illuminated how students retreat to silence, "follow the path of least resistance", and, in a climate of fear, do not report incidents of violence. As a nursing student in Myrick et al's study commented,[133] "there are not a lot of opportunities to have a good discussion to really resolve conflict and [that] has created a lot of boundaries for me in terms of what I am willing to ask and how much I am willing to put myself on the line with my instructors because I know it could potentially influence the end result [passing or failing] so heavily."[133] Not unlike practicing nurses, students in professional education programs commonly choose silence over dialogue, believing that any action of their part will not enhance their position when immersed in intraprofessional conflict.[133]

There is a paucity of research on violence toward nursing students, although elements of abusive practices are embedded in discourses on conflict[133] and anger in student-teacher relationships.[134] Internationally, Celik and Bayraktar's study of nursing student abuse in Turkey,[135] Bronner, Peretz, and Ehrenfeld's study of sexual harassment of nurses and nursing students in Israel,[136] Randle's three-year study of "bullying" among nursing students in the United Kingdom (UK),[45] and Stevenson, Randle, and Grayling's study of nursing students' experiences of bullying in their "work placement"[137] are notable exceptions. Apart from Theriault, Landry, Merritt-Gray, McLean, and Ericson's exploratory research project,[138] conducted by nursing students, which explored Canadian nursing students' perceptions and experiences with abuse in nursing schools across the country, no Canadian research on this troubling phenomenon has been reported. Remarkably, 100% of the 225 participants in Celik and Bayraktar's study of nursing student abuse in Turkey reported being verbally abused.[135] Verbal abuse occurred most frequently from their peers (100%) followed by the nursing faculty (41.3%). However, academic abuse – including disparaging remarks, hostility, and punishment through grade reduction – was very common (83.1%). Only two participants (0.9%) reported that they would deal with the incident by speaking to the abuser and "Doing nothing" (38.7%) was the most common coping mechanism reported. Stevenson et al.'s study showed that, over a three-year period, 95% of nursing students

were found to have below average self-esteem at the end of their education, a startling finding when all participants reported an average or high self-esteem when they began the program.[137] These research results provide compelling evidence attesting to the urgent need for multi-method research that addresses violence, including abuse in academic and clinical settings in nursing education.

Sustained exposure to violence across workplaces in general is known to have mental, physical and social health consequences, as well as financial and career outcomes for those experiencing it.[44,47,124,125] It is important to study to what extent these consequences influence the health-care workforce and whether, and to what extent, they have influenced not only the current shortages of health-care professionals across all health disciplines. Dire shortages in the nursing profession have been predicted. With the global nursing shortage looming as early as 2010 in the UK[89] and predicted shortages in North American, research addressing the image of the nursing profession is urgently needed.

Deans[61] found that abused nurses, in the absence of managerial support, experienced a lowered sense of "professional competence" that could lead to compromised patient health outcomes. In Diaz and McMillan's study on nurse-physician abuse, nurses reported withholding recommendations that would improve patient outcomes when dealing with a physician known to be abusive. For example, one nurse commented, "let him [physician] think for himself."[71] Nurses silently witnessing nurse-nurse, nurse-patient, and nurse-student abuse and failing to intervene effectively or offer support perpetuates "dis-empowering relationship patterns"[94] and contributes to the crystallization of a bullying culture in nursing. Workplace stress and violence have serious consequences for physical, mental and social health.[47,73,75,139] Clearly, the nursing profession can no longer tolerate the creation and reproduction of abusive practices in nursing education programs. There has been considerable debate about the theoretical underpinnings of workplace violence in nursing and how, through professional and occupational socialization, bullying practices are learned and perpetuated; however, there has been little research into this issue.[47]

It is not currently clear to what extent management practices may facilitate or hamper addressing violence in the workplace or whether such practices encourage or exacerbate patterns of violence.[61,91,120,121,140] However, it is known that, "in organizations where support for staff to report bullying are absent, those on the receiving end (victims) are often labeled by management as troublemakers, and coerced to resign, accept enforced redundancy, or take early or ill-health retirement."[137] However, "where employers handle bullying incidents well, the nurses concerned showed much less stress and dissatisfaction with their jobs and employers."[141] Research is required to explore the orientation and effectiveness of current management philosophies and supportive practices in relation to violence in the workplace.[142] We need to understand how to assess the impact of explicit management and leadership strategies on the occurrence of violence in the workplace and also on how it is prevented and addressed when it does occur.[61,75,120,121,140]

Linking concerns for nursing workforce retention with violence that has been embedded "within the nursing profession across a variety of institutional settings, including nursing faculties and professional bodies, for at least 75 years."[89] Stevens calls attention to a managerial culture that has dismissed bullying as a problem. While her case study-based research illuminates how a "bullying culture" can be successfully challenged, this discourse indicates that the roots of violence are woven inextricably into nurses' professional and occupational socialization.[45,143,144,145] Lewis' research indicates clearly that bullying activity is "essentially 'learned behaviour' within the workplace".[91] Clearly, the challenge of the nursing profession is to disrupt this cycle of learned behaviour by strongly weaving action-oriented strategies into the fabric of intraprofessional communication so that, taking contextual realties into account, violence is identified and managed so that healing relationships can unfold.

Violence in the workplace is not a new phenomenon and a wide variety of workplace-based approaches to address it have developed over time. Little is known, however, about the efficacy of most programs developed to address violence.[130,131] It is important to evaluate these educational prevention and intervention programs, as well as related policies to determine their efficacy. This research should include how the issue is framed within the organization and the approaches chosen for preventing and addressing it.[44,146-149]

The RNAO has developed and implemented a conceptual model to guide the orientation of best practice guidelines documents. Interprofessional researchers should design, implement, and evaluate research to examine the conceptual model and to assess its fit with, and utility in relation to, the concept of workplace violence.

3.0	Accreditation
	3.1 Accreditation bodies develop and implement standards in the accreditation process that support violence-free workplaces and incorporate recommendations contained in this guideline into their standards.

Discussion of Evidence[c]

The unhealthy environments experienced by nurses and other health-care professionals have been ignored, and hidden for too long and must be addressed. This includes the violent environment that exists in many settings that put both nurses, health-care professionals and patients/clients at risk.[150,151]

Accreditation bodies such as Accreditation Canada (previously The Canadian Council on Health Services Accreditation [CCHSA]), Canadian Association of the Schools of Nursing (CASN) and Ontario Council on Community Health Accreditation (OCCHA), must be diligent in assessing the health of the environment for workers and be committed to improving the quality of work life for nurses and other health-care workers. Therefore, it is important that they assess the organization's processes, structures and outcomes that support a violence-free workplace.[152,153]

In the United States, the Joint Commission declared that all organizations must have a code of conduct and process for addressing disruptive behaviour by January 1 2009. Disruptive behaviour is considered to be a threat to patient safety resulting in health-care errors.[55-57,154] This process will be reflective of the December 2007 Code of Conduct of the Joint Commission.[155]

New standards developed in 2007 incorporate components of a healthy work environment and its links to staff, organization and patient/client outcomes into the Accreditation Canada (formerly CCHSA) process. Specifically, the new process addresses issues related to: work life balance; appropriate use of health human resources based on knowledge and skill; ensuring a physically safe and healthy work environment for health-care workers; and initiating practices to enhance patient/client/staff safety[58,153] The physical, social and psychological aspects of the workplace must be reviewed during the accreditation process if a truly healthy work environment is to be achieved.[154]

[c]Type of Evidence – There is B, C and D type of evidence to support this recommendation

4.0	Education
	4.1 Education for all health-care professionals includes: a. Formal and informal opportunities for discipline-specific and interprofessional students to develop and demonstrate the ability to recognize, prevent and manage violence in the workplace. b. Opportunities for students to learn how to protect themselves from violence in the workplace. c. Appropriate communication strategies for responding to conflict and/or "escalating aggression" in the workplace from patients, peers and other health-care professionals, supervisors and faculty. d. Learning related to how, and when, to use formal reporting methods for addressing violence in the workplace. e. Supporting students in recognizing the impact of violence in the workplace on health, career and life, and encouragement to seek individual, organizational and systemic solutions. f. Opportunities for participants to examine the workplace culture using critical social theory perspectives. g. Ensuring that students are informed and adhere to academic and service health and safety policies and procedures related to the prevention and management of violence in clinical placements.
	4.2 Education programs and educators for all health-care professionals: a. Recognize that intended and unintended forms of incivility, aggression and violence enacted in academic and clinical settings can serve to reproduce and escalate violent behaviours and practices between and among all health-care professionals in academic and health-care organizations. b. Review and respond to recommendations from coroners' inquests to ensure that programs are in keeping with the development of a workplace free of violence.
	4.3 Academic settings role model a violence-free environment and culture by fully adhering to their organizational policies, procedures and practices, and augmenting any gaps in those with recommendations included in this guideline.

Discussion of Evidence[d]

Recognizing violence in the workplace is not automatic. Workplace violence is not always recognized by targets, and it is often brought to their attention by colleagues who have observed such behaviour over a period of time.[91] Undergraduate and graduate nursing education programs and nurse educators in health-care workplace programs need to be attuned to the prevalence and reproductive nature of violence in the workplace in all settings. However, recognizing violence in the workplace[156] is challenging, because it frequently goes under the guise of workplace harassment,[91] abusive behaviour,[157] mobbing,[158] horizontal violence,[44] hostility[134] and workplace bullying.[159] More recently, the nursing discourse has focused on incivility,[132,134] a gentler term for violence and abuse. Incivility was perceived by 70% of Clark and Springer's nursing faculty and student participants as being a "moderate or serious problem."[132]

In their workplaces, nurses rightly anticipate being treated as professionals, so experiencing violence in the workplace is often shocking. While physical, sexual, and psychological harassment and bullying occur, the most common form of violence experienced by nurses is psychological. Of psychological abuse, verbal abuses most commonly experienced by nurses are condescension, abusive anger, being ignored and humiliation.[160] Recognizing that this behaviour is unacceptable is an important first step in being able to manage or prevent it. Nurses should be prompted often about

[d]Type of Evidence – There is B, C and D type of evidence to support this recommendation.

reporting work-related bullying, physical assault and harassment, and managing assaultive/violent patients/clients[149] and other incidents.

Students who learn to identify violent situations are better able to recognize them early and to prevent them from escalating.[91,161] Early intervention is key to addressing violence in the workplace and serves a protective function against long-term consequences.[61,162-164]

Undergraduate nursing curricula fail to prepare nurses to address interpersonal abuse,[44,138,165,166-168] as well as relational abuse. Abuse-focused clinical competencies have not been developed in the majority of nursing curricula and abuse-related faculty development is virtually non-existent.[168] While some nursing faculty avoid interpersonal conflict[134,169] or engaging in abusive tactics,[170] other nurses and nursing students report feeling ill-equipped to respond professionally in abusive situations involving patients/clients or co-workers.

Students' perceptions that faculty can play a significant role in academic incivility has been reported in the literature.[132,134] As one student commented, "Incompetent, rude professors encourage the same rude behaviour in students … Students are frustrated by the lack of resources to report [such behaviour] and fear retaliation if they go to the top to report it. We've been told that it can cost us our degrees and that we'll be flunked out if we speak up. This simply encourages incompetence and incivility to continue."[132] Educators engaged in teaching-learning processes in health-care and academic settings must recognize that intended and unintended forms of incivility, aggression and violence can serve to reproduce and escalate abusive behaviours and practices in the nursing profession.[171]

When nursing students are learning the profession in various settings where violence is known to occur, nursing education programs and educators have a moral imperative to ensure that students and graduates have achieved competencies in preventing and managing aggression that can escalate into more extreme forms of violence.[127] Very little research in nursing or higher education has been conducted on student incivility, or the contributions faculty may make to incivility in the academic environment.[132]

Employers need to provide continuing education sessions to all staff concerning intimate partner violence in the workplace and various other forms of violence in the workplace. This would serve to increase knowledge and awareness about interpreting others' body language and other signals indicating their potential for violence[172] and would expand workers' awareness of potential violence from perpetrators other than patients/clients.

Currently, violence in the workplace is thought to be underreported for a number of reasons. In some situations, there may be peer pressure not to report. Sometimes there is ambiguity about what constitutes violence in the workplace and, therefore, what should be reported. Nurses may have come to identify violence as part of the job and many may wonder if they themselves precipitated the violence. There may be conflict between nurses' perceptions of their roles as caregivers versus their role as targets. Many nurses report that they fear lack of support by employers and escalation of workplace hostility if they do report violence. Few believe that reporting violence will be effective in diminishing its occurrence.[173]

Research has shown that education about specific topics significantly increases the reporting of work-related assaults by patients/clients. These topics include managing assaultive patients/clients, reporting work-related physical assault, self-defence and knowledge of the risk factors of violence.[149] These topics can also be effective in improving reporting of violence by other perpetrators. Additionally, education sessions about violence in the workplace related to such topics as what constitutes violence or unacceptable behaviours, contributing factors, areas of assessment and potential solutions, frameworks for managing aggression and related ethical/legal issues may be effective.[174] Educational posters and in-service sessions can assist in raising both knowledge and awareness of therapeutic tools such as de-escalation techniques.[147]

It is also the responsibility of employers to educate nurses on why they should report violence in the workplace and to eliminate perceived barriers to reporting.[162] Employers have responsibilities related to establishing mechanisms to provide debriefing and support for nurses following abusive experiences – for those both directly and indirectly involved.[162]

Employers may implement effective staff education in interpersonal and communication skills that includes recognizing escalating behaviours and warning signs of potentially violent situations, appropriate communicate techniques emphasizing conflict resolution and negotiation, control of staff feelings/ behaviours, and recognizing post traumatic reactions.[99] These strategies are important, regardless of the source of the violence.

Violence in the workplace can include intimidation, lack of respect, coercion, and more subtle behaviour such as criticism or belittling in private.[47] Some studies indicate that bullies were aware of the damage they were doing, and they undertook actions to gain control and power.[91] These bullies were often insecure, fearful or jealous, and they bullied to protect themselves; others were seen as: deliberately disruptive, intrusive and thriving on confrontation; showing contempt for difference; ruthless; impervious to the criticism of others; unable to assess their own behaviour; manipulative; and narcissistic.[47] In other situations, bullies have been thought to be unwitting perpetrators.[47] Whether intentional or not, bullies assert power (formal or informal) over others and dominate and diminish them.[47] In some instances, bullies control work roles, tasks and status by enforcing their own rules.[120,121]

RECOMMENDATIONS

Current research has found that second-year nursing students reported more exposure to bullying than first- and third-year students, possibly because they have been in clinical placements longer and have developed the sufficient professional maturity to recognize it. They also have greater ability to manage inappropriate behaviour.[164] In this study, most bullies were experienced nurses, with registered and buddied nurses being the most commonly reported sources.[164] It is shocking that 52% of students reported that they expected to be bullied while on clinical placements.[164] Fortunately, 86% of students were able to talk to a confidante about their bullying experiences – usually a lecturer/tutor or classmate.[164] Within this culture of anticipated violence, critical examination of the workplace status quo is unlikely to be perceived as safe.

Students and new graduates require ongoing support to break the cycle of violence in the workplace. For example, educational programs can be developed in the workplace to be used as a guide for dealing, both formally and informally, with violence in the workplace.[141]

"That bullying behaviour has been operational and 'normalized' for some time makes it quite difficult for the victim to suddenly challenge and change it … The culture of nursing may provide the almost perfect habitat for the manipulative bully. Powerlessness infects lower-status health-care workers, such as nursing students or new [graduates], who are made to feel they have failed if they seek help in dealing with quite realistic demands."[137]

Educators must provide opportunities for graduates and students to learn how to protect themselves from the whole range of violence in the workplace.[61,162-164] Additionally, educational programs must provide opportunities for learning appropriate communication strategies for responding to conflict and "escalating aggression" in the workplace from peers and colleagues in positions of power.[61,175,176] Educational programs must provide opportunities staff to co-create and enact formal reporting methods for addressing violence in the workplace.[44,126,177,178]

5.0	Professional, Regulatory and Union Bodies
	5.1 Professional, regulatory and union bodies for health-care professionals: a. Serve as role models through the creation of safe, respectful and violence-free environments within their workplace's staff, board of directors, committees and volunteers. b. Establish outreach programs that address violence in the workplace. c. Reflect the importance of safe, respectful, violence-free working environments in all applicable policies, standards, guidelines and educational materials developed by the organizations. d. Develop and collaborate with others to communicate common education and advocacy messages, that advance violence-free working environments. e. Educate health-care professionals and the public regarding violence in the workplace, including systemic, organizational and individual prevention, early detection and management. f. Review and respond to recommendations from coroners' inquests to ensure that standards and educational programs are in keeping with the development of a workplace free of violence.

Discussion of Evidence[e]

Recommendations for all health-care and community care professional organizations and regulators are based on the fact that policy making, standard setting and politically active bodies play an integral role in supporting the development of a healthy work environment.

All health-care and community care professional organizations and regulatory bodies are in a pivotal position to offer, and indeed hold organizations accountable for, change on particular issues. For example, when issues such as ethics, patient safety and satisfaction, and quality improvement are identified for attention by such agencies, organizational commitment and support often follow. Such coordinated efforts also lead to the development of indicators, national standards and benchmarks for internal and external comparison, as well as guidelines and support. The end result is the development of knowledge, practice and, ultimately, optimal patient outcomes. The process benefits from a collaborative, interprofessional approach.

Professional organizations and regulatory bodies can have a tremendous influence on individuals within their profession through standards, best practice guidelines, continuing education workshops and other types of formal and informal dialogue. These bodies create the expectations and culture of the profession, and also contribute to its health and well-being. By supporting a violence-free workplace as a core value, professional and regulatory bodies are in a pivotal position to promote the development of a violence-free philosophy in all aspects of the health-care professions and the community care as a whole. Through outreach, role modeling respectful behaviour[179] and lobbying, these bodies can – both collaboratively and independently – leverage their power, position and influence to foster healthy work environments for all.[107,109,163]

[e]Type of Evidence – There is D type of evidence to support this recommendation.

Organizational Recommendations

The following recommendations are organized using the Healthy Work Environments framework and reflect physical/structural, cognitive, psychological, social, cultural, professional and occupational components of preventing violence in the workplace that must be addressed at the organizational level to ensure best practice. The organizational factors that are identified in the various components include:

Physical/Structural components:

- Physical characteristics and environment of the organization
- Organizational structures and processes created to respond to the physical demands of work (e.g. span of control of managers, decision-making processes)
- Leadership support
- Staffing practices
- Occupational health safety policies
- Rewards and incentives that encourage and promote a violence-free workplace

Cognitive/Psychological/Social/Cultural components:

- Organizational climate, culture and values
- Cultural norms, especially those that foster trust and respect
- Organizational hierarchy, and how it influences power dynamics
- Organizational stability
- Communication practices
- Labour/management relations
- Culture of continuous learning and support

Professional/Occupational components

- Characteristics of the nature and role of the nursing within the organization, including organizational policies that influence scope of practice, level of autonomy and control over practice
- Intraprofessional and interprofessional relationships within the organization

6.0	Organizational Recommendations
	6.1 Service and academic organizations promote and support a workplace free of violence by: a. Ensuring that the safety of staff, physicians, volunteers and students is aligned with the organization's values and is a strategic priority which is fully integrated into corporate and service specific goals. b. Developing and implementing a violence prevention policy and program that addresses all forms of violence in the workplace. The policy and program adopts clear codes of behaviour that guide all internal and external stakeholders in addressing all forms of violence or potential violence and institute mandatory reporting as well as whistle-blower protection for those who report incidents of actual or potential violence. c. Identifying situations where there is imbalance of power, such as employer/employee, physician/nurse, student/staff and ensuring structural changes to equalize power bases, as this is a key contributor to aggression. d. Ensuring structures and processes are in place that enable all health-care professionals to have a shared role in organizational and clinical decision making. e. Adopt patient/family/relationship-centred care models and introduce strategies to promote respect among all members of the health-care team, patients/clients and other stakeholders. f. Identifying strategies to recognize and respond to employees' personal situations that may expose themselves, and other co-workers to violence danger. g. Ensuring that any disruptive behaviour by employees, physicians, volunteers and students is addressed in a timely manner through performance improvement/disciplinary processes that include competencies related to promoting a violence-free workplace. h. Reviewing and responding to recommendations from coroners' inquests in keeping with the development of a workplace free of violence.
	6.2 Service and academic organizations introduce the appropriate controls to establish a comprehensive prevention program and continuously monitor the progress towards a violence free workplace by: a. Conducting ongoing risk/hazard assessments that include employees, physicians, volunteers and students input to ascertain the risk of potential and actual violence in the workplace including monitoring incidents of actual and potential violence so that specific strategies for ongoing improvement can be identified. b. Ensuring that appropriate environmental, administrative, work/care and safety practices are implemented to promote a violence-free environment.
	6.3 Service and academic organizations ensure all employees, physicians, volunteers and students have the knowledge and competencies related to promoting a violence-free, healthy work environment by: a. Providing resources for ongoing mandatory education. b. Educating all administrators, clinicians in all roles, and support staff on how to respond to and manage violence in the workplace, including implementation and evaluation procedures. c. Creating and delivering a clear communication strategy to ensure that all persons who have a relationship with the organization are aware of the violence-free program including the processes for mandatory reporting and responding to incidents of violence in the workplace.

	6.4 Service and academic organizations develop and implement a process to evaluate the violence in the workplace prevention program by: a. Developing and monitoring organizational accountability. This would include, but not be limited to, indicators to measure effectiveness of prevention programs, prevalence and incidence of violence, as well as fair and consistent response to reported violence regardless of the power base of those involved in the violence.
	6.5 Service and academic organizations create a strategy for immediate and organized response to direct threats of violence by simultaneously: a. Ensuring safety/security measures are immediately implemented. This includes contacting police when appropriate. b. Immediately investigating all reports of direct threat of violence. c. Securing timely response measures, corrective action, assistance and support to target(s), and appropriate follow up. d. Making workplace accommodations such as, but not limited to, changing staff schedules and/or making work/study re-assignments as necessary.

Discussion of Evidence[f]

Clearly, an unsafe environment has negative consequences for clients, employees and employers.[180] When verbal or physical violence against nurses is tolerated, the messages are sent that violence is condoned and nurses are not valued. If nurses are to support others, they must feel supported and safe themselves. Leaders must ensure a violence-free workplace in order to protect staff, clients and the public. To promote reporting of violent incidents a violence-free workplace policy should include protection for whistle blowers. A consistent approach to ensuring a violence-free workplace is necessary.[70] Exposure to violence in the workplace influences nurses' distress, their desire to stay in the profession, productivity and the potential to make errors.[61,181,182]

Hierarchal organizational structures are reported to promote violence in the workplace.[112] In many of the studies, physicians account for the majority of the instances of violence.[54-57,118,183-188] Promoting a non-hierarchal organizational structure that promotes collaboration is crucial to eliminating workplace violence. Pieper[189] recommends that the Chief Operating Officer (COO), Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) have equal footing in health-care organizations and that the CNO and Chief of Staff co-chair professional advisory committees.

Patient safety is also an issue when physician-disruptive behaviour and other forms of workplace violence occur.[54-57] Patient safety is reported to deteriorate when workplace violence is prevalent and near misses and adverse outcomes have resulted.[53,183,190]

Workplace violence may result in psychological distress and have other potential impacts on the individual such as injury, physical and/or psychological impairment, permanent disability, post-traumatic stress disorder and even death.[191] There is compelling evidence to indicate that providing emotional support post incident may reduce the risk of disabling emotional and physical illness.[124,125,177,192-194] In a survey of 1200 nurses reported that 90% of respondents had witnessed violence and 33% knew a nurse who left her position because of it.[190] As nursing shortages continue it is important for organizations to develop strategies that retain nurses and eliminate cultures that cause them to leave.

[f]Type of Evidence – There is B, C and D type of evidence to support this recommendation.

Strategies are necessary to create practice environments in which a culture of work-place violence is unacceptable, and real and meaningful strategies are in place to reduce and prevent actual occurrences of violence. The key to creating a safe, violence-free workplace lies with decision-makers and professional organizations.[195]

When policies and programs are in place – including mandatory violence prevention programs – there is a greater awareness of violence, enhanced knowledge of how to assess and report it. Further, it is more likely that solutions will be identified[147] and incidents of violence reduced.[149]

It has been shown that bullying (horizontal violence) is found in work environments where management is viewed as non-supportive.[88,91,196] In workplaces without relevant policies and procedures, it is more likely that acts of bullying will be covered up.[160] Organizational factors that precipitate bullying include job design, workplace culture, organizational change and restructuring.[61,120,121] It is clear that health-care institutions must place a value on the way employees treat each other if violence in the workplace is to decrease.[88,196,197] Employers should also ensure that supportive services are made readily available for all new graduates who experience horizontal violence in order to prevent possible psychological sequelae. Emphasis should be placed on preventing horizontal violence, including primary prevention strategies that begin with education and staff training.[44]

Organizations should ensure the development of transition programs for new graduates, including the development of preceptors and mentors who are sensitive to these issues, and who can teach strategies to identify the potential for violence and interventions related to prevention.[44] Education is key for those with less experience as the evidence suggest they are at greater risk.[104]

Along with stronger organizational mandates and a climate willing to heed to the nurse's situation in cases of violence, educational interventions to promote skills in preventing and responding to violence must be implemented. The skills required for preventing and responding to professional-to-professional violence are different from those needed for client-nurse violence situations, and appropriate development should be taken. Nurses who have the greatest difficulty in responding to violence need mentors to support them in handling these situations. Opportunities for nurse-physician collaboration must be provided to improve overall communication and prevent violence against nurses in the workplace.[88]

Education and awareness programs increase the frequency of reporting of work-related violence, knowledge of risk factors,[149,161,162] and confidence of staff when dealing with violence.[175] Education related to violence and aggression in the workplace has been found to be relevant and valued by respondents in practice, however, it was not found to be delivered as frequently as staff would have liked and it was not always well monitored.

Policies must be interpreted in a humane manner, taking individual situations into account. It has been suggested that tailoring education more accurately to staff needs and offering a selection of modules should be a priority.[198,199] Education of all staff to assist them to prevent and manage workplace violence is imperative; however, a 'one size fits all' educational program or policy would be ineffective.[182] An awareness of those staff characteristics that do have an impact is necessary to develop aggression prevention strategies and staff education programs in an attempt to modify these contributors to aggression.[200]

Recognition and reporting of violence is significant in ensuring a violence-free workplace, but requires support from colleagues, employers and appropriate systems of support.[201] Senior leaders should encourage and support reporting of violence in an effort to adequately determine the level of violence experienced by employees.[162] With increased awareness, more reporting should occur.[180] Also, as mentioned previously, a policy should protect those who report the violence.

Violent acts are not reported for a number of reasons. Mahoney[202] states that nurses "believe that there was insufficient time to complete reports (on violence) and that no real benefit was gained from reporting incidents."Nurses believe that"nothing will be done" if a report is made.[201] Combined with the recognized issue that violence in the workplace is not reported,[202-205] or ignored if it is reported,[206] it becomes apparent that to gain insights about the issues surrounding workplace violence one needs to explore the experiences of the worker.[207]

An alarming 67% of the nurses in the Duncan et al survey[208] indicated that they had not reported incidents of violence. The underreporting of nurses' experiences with violence raises troubling questions about whether we have accepted a culture of violence against nurses in our hospitals. The first and critical step to improving conditions is to report each and every occurrence.[195] It is imperative that there is a supportive work environment that encourages reporting of all assaults, without automatic blame.[209,210]

Underreporting of violent events occurs when an individual is victimized and does not report the event to an employer, police, or through other means. Measures should be taken to enhance reporting by all employees. Those with greater symptoms appear more likely to report violence.[162]

Several factors have been identified as reasons why nurses fail to report assaults in the workplace: peer pressure not to report;[211] conflict between what the nurse views as his/her professional role vs. being a victim;[212,213] ambiguity in defining violence;[211] fear of job loss;[214] the intent of the patient to commit harm[211] perception that violence is part of the job;[211,213] fear of blame of causing the assault;[213,215] the perceptions that, when reported, assaults may be viewed by employers as the result of negligence, poor job performance, or that reporting brings no personal benefit.[173,178]

Many violent acts remain unreported, however, small increases in reporting alone might have huge effects.[173,180] Underreporting may be related to an acceptance of a culture of violence in hospitals, particularly by mid- and late-career nurses. Underreporting may also be related to nurses' reticence to disclose violence to hospital administrators.[105,177,216]

Monitoring procedures and reporting systems should be in place, regardless of the perceived root causes or nurses' responses to the incident.[197] A significant organizational strategy involves the collection of accurate occupational health data, as a tool for identifying trends, and for developing and evaluating effective interventions.[161] In addition is the importance of audits and regular monitoring are important strategies to ensure reporting.[130] For example, the evidence suggests that only one in five violent incidents is reported in nursing environments without such audits/monitoring procedures.[217]

An effective workplace violence prevention program requires clear reporting procedures and a strategy for data collection and analysis.[218] Organizational factors that discourage reporting include apathy, ineffective reporting processes, poor documentation,[219] peer pressure not to report, ambiguity in defining violence and a perception that violence is part of the job.[173]

Leaders should promote open dialogue, including measures to decrease risks and promote safety, being alert to warning signs, and assisting workers in potentially dangerous situations.[173] Commitment of the CEO[220] and the development of policies, procedures and education modules that address workplace violence are key to ensuring that staff are aware that workplace violence will not be tolerated.

Organizations must ensure environments where there is not only a positive culture but appropriate resources for staff.[102] The organizational culture must be conducive to openness and transparency, where no type of violence is

tolerated or accepted as "part of the job" in any circumstance. Each incident should be reviewed and strategies to prevent or manage violence should be developed and implemented. This has added significance as we face the challenge of attracting young people to nursing and ensuring an environment where they will remain.[54,70,98,188] Strong leadership may be required to change organizational cultures and ensure violence-free workplaces. Prevention strategies are key to a violence-free workplace. An organization must implement adequate safeguards and procedures to prevent violence and be held accountable for recognizing the potential of violence in the workplace. A major step in reducing the risk for workplace violence is to develop written policies that clearly indicate that all violence should be addressed, whether the violence originates inside or outside of the workplace.[173,221-223]

Having the organizational and staff commitment to violence prevention is a critical starting point for a violence prevention program and crucial to its success. Maintaining open lines of communication and ensuring that all members of the organization clearly understand the scope of the violence prevention program are crucial to ensuring its ongoing support among employees.[224,225] For example, anti-discrimination/harassment policies should be developed, implemented and enforced in collaboration with the Joint Health Saftey Committee (JHSC), unions and front-line staff. The policies should clearly outline acceptable and non-acceptable behaviours.[196]

Organizations must consider it a strategic priority to provide the funding and mechanisms to ensure that highly competent security teams are in place.[44] Employees need to be assured of their safety and have trust in leadership's commitment to ensuring an emergency response mechanism that focuses on providing assistance to staff.[226]

Employers must review and institute security measures, improve communication that prevents aggression and enhances collaboration among personnel, improve screening of potential employees, and modify environmental factors that could increase the risk of violence.[173] Environmental controls such as alarms and lighting should be considered.[86] Violence prevention controls include facility and unit security assessment, and security technology (e.g. metal detectors, video surveillance, panic buttons, personal alarms, intercom doors, card-only access areas and key-coded doors).[227]

Nursing leaders should make themselves available to staff who have experienced violence. A sensitive, fair, transparent and consistent process for investigating incidents of violence is required.[196] It is uncertain whether senior leaders are aware of the extent of the problem of workplace violence and their own role in its perpetuation. A professional nursing culture that acknowledges its own contribution to the problem can contribute to individual and professional recovery.[61]

When violence does occur, programs are necessary to stabilize and prevent acute psychological distress and adverse post-traumatic psychological illness (i.e. post-traumatic stress disorder).[191] Evidence supports the effectiveness of critical incident stress debriefing interventions in preventing post-traumatic stress disorder.[228] Victims should be assessed regarding the need for intervention based on observable signs and symptoms of distress and dysfunction,[229] and to determine both the appropriateness and timeliness for the intervention. Premature intervention may interfere with the body's natural recovery process in some victims, and should be based on a person's psychological readiness.[229]

Verbalization of a traumatic experience by a victim requires successive therapeutic sessions[230] that have been found to have adverse effects on victims of violence.[206] Richards[231] concluded that interventions offered through a multi-component Critical Incident Stress Management (CISM) program with multiple interventions were more effective than single-session critical incident debriefing.

The most widely supported CISM programs in the literature are formal, multi-component programs. Examples of such programs include the CISM program, the Critical Incident Stress Debriefing (CISD) program and the Assaulted

Staff Action Program (ASAP). The CISM and CISD, both multi-component programs, focuses on interventions to decrease the effects of critical incident stress.[232] ASAP is actually a variation of the CISM approach, and is a voluntary, system-wide, peer-supported and multifaceted program designed to assist employee victims following acts of workplace violence.[191,233]

The importance of multiple interventions, such as those included in multi-component programs, are supported in the literature by most researchers as the only successful method of stabilizing the victim and mitigating symptoms. However, the multi-component program is often incorrectly perceived as being separate stand-alone programs rather than an integrated whole and as such, is sometimes compared with stand-alone interventions such as the single-session informal debriefing sessions. Furthermore, the efficacy of these stand-alone sessions has been recently challenged while the effectiveness of multi-component programs, such as the CISM and CISD, have been validated through various qualitative analyses, controlled investigations and meta-analysis.[234] It is important to note that the literature emphasizes that the term "debriefing" should not be confused with interventions through a multi-component critical incident stress debriefing program such as CISM.[235]

The literature supports that critical incident stress debriefing is an important part of workplace violence prevention programs; employers who have a risk of workplace violence have both legal and ethical responsibilities to provide an appropriate level of support to meet the needs of their employees post violent and/or traumatic incident.[236]

The literature widely supports that a skilled professional – such as an advanced practice nurse with specialized skills – is required to skillfully assess and treat employee victims following a critical incident. Eligibility requirements for a CISM crisis response provider include a Master's preparation in a mental health field with five years of experience in crisis intervention.[237]

It is recommended that an interdisciplinary crisis response team that includes members from human resources, front-line employees, union members, security, management, administration, public relations and occupational health and safety be established and educated.[238] These crisis management team members should meet regularly to discuss potential crises, plan crises response and review strategies.[239] Team members and employees should be educated to recognize that external community resources may be required. Anecdotal evidence suggests the importance of senior management support of crisis intervention teams.[240]

Empowering employees to be assertive in their attempts to stop violent behaviour may not only reduce the behaviour, but also allow organizational resources to be focused on more serious incidents.[162] Results have highlighted the importance of educating nurses and managers to provide support to victims of occupational violence. Nurse managers should receive comprehensive and carefully focused education related to how to support the role of Registered Nurses.[61,241]

An organization's violence prevention program should be evaluated: as part of the overall health and safety program; on an ongoing basis to identify and correct any problems; formally and in depth at least once a year; when changes occur in the workplace, such as when an aspect of the overall delivery of care changes, or when structural modifications are made to the building; as a result of recommendations from an investigation of a violent incident.[224]

As part of their overall occupational health, wellness and safety program, employers should evaluate their safety and security program. Senior leaders should review the program regularly and evaluate the program's success after each incident. Responsible parties (manager, supervisors and employees) should collectively reevaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.[225] Employers should evaluate this program periodically.

Employers of nurses need to provide measures and procedures for the health and safety of their staff as established under section 8 (HCR). These include safe work practices; safe work conditions; education regarding proper use, maintenance and operation of equipment; reporting of unsafe or defective devices, equipment or work surfaces; and the use, wearing and care of personal protective equipment (HCR S.9(1)). A review of processes that protect staff from workplace violence should be included with the annual review and revision of these measures and procedures.

Team/Individual Recommendations

The following recommendations are organized using the Healthy Work Environments framework and reflect physical/structural; cognitive, psychological, social, cultural; and professional and occupational components of preventing violence in the workplace that must be addressed at the individual level to ensure best practice. The individual factors that are identified in the various components include:

Physical/Structural components

- Work demands
- Work design
- Work characteristics
- Workforce composition

The Cognitive/Psychological/Social/Cultural components

- Cognitive, psychological, and social capabilities and effort
- Cultural competency
- Gender
- Working relationships: communication patterns, decision-making, conflict resolution and member mentoring
- Role clarity
- Role strain
- Emotional demands
- Job security
- Clinical complexity
- Clinical knowledge, coping skills, communication skills

Professional/Occupational components

- Experience, skills and knowledge
- Personal attributes
- Communication skills
- Motivational factors

7.0	Team/Individual Recommendations
	7.1 All employees, physicians, volunteers and students: a. Acquire the knowledge and competencies to prevent, identify, and respond to potential violence. b. Engage in self-reflective practice and examine how one's behaviour impacts others and how the behaviour of others impacts them. c. Practice and collaborate with team members in a manner that fosters respect, trust and prevents violence. This includes refraining from as actions such as gossiping, bullying, harassment, socially isolating others, pushing, throwing elements, or any other behaviours that constitute aggression. d. Contribute to the development of organizational strategies to prevent, identify and respond to violence. e. Fully adhere to organizational policies, procedures and practices related to preventing, identifying and responding to workplace violence. f. Follow organizational processes related to mandatory reporting, seeking support and providing support to others when potentially violent situations are identified or violent situations occur.

Discussion of Evidence[g]

Violence in the workplace arises when groups or individuals are allowed to undermine the work of others. Violence is a learned behaviour perpetrated by persons who are often insecure, fearful, or jealous and who use violence as a means of protecting themselves.[47] It is allowed to continue when the antagonist is unaware of the impact their behaviour has on others and when violent events go unreported.[47,91]

Nurses, professional colleagues and patients/clients can all be sources of violence. Nurses are often ill equipped to handle the many forms of violence they face. Strategies to identify and reduce violence must be learned. For example, identifying potentially violent situations, recognizing precipitating factors and critical events, and having the knowledge and skills to de-escalate a situation are all strategies that can reduce violence in the workplace.[104,130,176,243,244]

Regular education about reporting and managing violence and other distressing events is suggested by several sources, and the nurse must take an active role in seeking out and participating in such educational opportunities.[47,172] Education can facilitate reporting of violent incidents by making reporting acceptable (if not mandatory), providing clear definitions of violence and helping nurses to appreciate that experiencing violence must not be viewed as a normal part of their work environment.[149]

An alarming 70% of nurses indicated that they had not reported violence when it had been perpetrated upon them. The underreporting of nurses' experiences with violence raises troubling questions about whether we have accepted a culture of violence against nurses. The first and critical step to improving conditions is to report each and every occurrence.[195] However, nurses often experience further intimidation when they report an abusive or violent incident, and therefore are silenced.[185]

In many studies, the most frequent perpetrators of violence toward nurses are physicians.[54,115,117,118,188,245] A hierarchal organizational system that confers a higher status upon physicians is reported to result in more abusive situations.[54,117,186,188] Collaborative organizational structures promote professional respect and improve working relationships and support a workplace free of violence.[107]

[g]Type of Evidence – There is B, C and D type of evidence to support this recommendation.

Nurses need to be self aware and reflective of their actions and behaviour, and aware also of the impact of the behaviour of others, in order to make the cultural shift in thinking such that no form of violence will be accepted in today's workplaces. The Standards of Practice for the College of Nurse of Ontario state that each nurse is responsible for developing and maintaining respectful and collaborative therapeutic and professional relationships.[246] It is important to educate nurses and managers to provide strong support to nurses who are victims of violence and those who have witnessed violent situations.[61,126,140] Nurses who have experienced violence in their workplace that has not been addressed properly or satisfactorily may become cynical about nursing and complain about lack support from within the profession.[61]

Those who witness an incidence of violence require support services to enable them to redevelop trust in their employer and co-workers. Debriefing with all involved is a useful support strategy and begins the process of healing. For nurses who have experienced bullying, they may be encouraged by adapting such coping strategies as engaging in positive self-talk, emphasizing their intent to maintain their own integrity, engaging in stress-releasing activities, and accessing both formal and informal sources of support.[47] Because bullying is not always recognized by targets and may be brought to their attention by observant co-workers,[91] heightening awareness of everyone within workplaces improves the chances of recognizing it and subsequent protection from it.

When possible, nurses should take action if they have been bullied. Such action includes: talking with friends and colleagues, reporting it to managers, filing formal complaints or grievances and confronting the bully.[126] Most of these actions are appropriate under organizational health and safety policies.[141,173,247] Collaborative practice and problem-solving among team members supports the concept of team, building common values, beliefs and responsibilities which both reduces intercollegial violence and assists in effectively managing violence in the workplace.[107,140,173,181,248]

Evaluation and Monitoring of the Guideline

Organizations implementing the recommendations in the Healthy Work Environments *Preventing and Managing Violence in the Workplace* Best Practice Guideline are encouraged to consider how the implementation and its impact will be monitored and evaluated. The following table, based on the Conceptual Model for Healthy Work Environments illustrates some examples of indicators for monitoring and evaluation. Many of these indicators can be measured through the use of one or more of the measures of concepts related to the Healthy Work Environments model.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Objective	To evaluate the supports that promote a violence-free work environment for nurses	To evaluate violence prevention and management processes	To evaluate the impact of implementation of the guideline recommendations at all levels	To measure and monitor indicators of structures, processes and outcomes
Organization/Unit	Specific plans within the organization to implement the *Preventing and Managing Violence in the Workplace* guideline Structures consistent with recommendations related to organizational supports are evident in the organization such as: • crisis team • client-centered care • safety practices • physical environment • respectful workplace efforts and education • Collaborative interprofessional orientation and preceptorship programs that are comprehensive and tailored to new staff needs • Access to educational opportunities related to *Preventing and Managing Violence in the Workplace*	Communication mechanisms established and used such as: • newsletters • open forums • access to email • team meetings • interdisciplinary patient care rounds • communication book Code white processes Violence prevention and management policy Monitor safety documentation of environment changes as a result of audits	Organizational outcomes such as • Turnover rates • Sick time • Retention rates • Critical Incidents of violence against nurses • Increase in safety • Exit interviews • Internal transfer rates • Assess safety through audits	Accreditation standards achieved Exits interviews and retirement interviews Human resources statistics, baseline and trends over time related to nursing staff mix, number of staff, turnover, sick time, retention of nursing staff in all roles Safety audits Number of violent incidents reported, including severity, time lost Esteem/respect scale[249] Interactional justice[250] Turnover Intention Scale (subscale of the Michigan Organization Assessment Questionnaire)[251] Confidence in Coping with Patient Aggression Instrument[53,252] Number of persons studying advanced education

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Organization/Unit cont.	• Partnerships with educational institutions to provide formal collaborative education • Role descriptions include expectations of respectful collaborative behaviours	Continuing education promoted through support and flexible staffing for all levels of the organization Respectful working relationships are promoted through human resource development processes		Funds for continuing education in relation to violence prevention in the workplace Practice Environment Scale of Nursing Work IndexWI[253] Professional Practice Environment Scale[41] Canadian Practice Environment Index[195] Quality Work Environments for Nurse and Patient Safety[254]
Nurse/Team	Support for individuals in all roles related to developing knowledge about the values and behaviours that promote a violence-free workplace for nurses Number of individuals who access violence prevention education	Nurses in all roles demonstrate respectful communication and collaborative practice competencies to prevent and manage violence in the workplace Regular performance appraisal conducted, including self-assessment Teamwork and collaborative practice behaviours, including respect, are assessed as part of performance appraisal Processes are in place to promote communication throughout all shifts for all nurses.	Nurse/Team outcomes such as • Nurse satisfaction • Self-efficacy • Work engagement • Motivation • Organizational commitment • Coordination • Collaborative decision-making • Assessment of quality of learning experience • Satisfaction with nursing and learning experience • Involvement in interprofessional learning opportunities • Number of nurses expressing intent to leave	Number accessing program performance appraisal Impact of Patient Aggression on Carers Scale[124] Negative Acts Questionnaire-revised (exposure to bullying behaviours)[255] Scale of Aggressive and Violent Experiences (SAVE)[256] Areas of Worklife Scale[257] Maslach Burnout Inventory – Human Services Scale[258] Intragroup Conflict Scale[259] Verbal Abuse Scale[260] Impact of Events Scale[261] Esteem/Respect Scale[249] Interactional Justice[250] Unit Communication & Coordination[262]

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME	MEASUREMENT
Patient/Client	Quality improvement programs are in place	Ongoing monitoring of effects of violent incidents Processes for patients/clients to provide feedback are explained to patients/clients and accessible Rights and responsibilities of patients/clients are clearly outlined and communicated	Number of reported incidents of violence in the workplace Patient/client satisfaction with the experience Documented patient/client feedback Number of unresolved care issues	Documentation around response Number of violent incidents reported, including severity, time lost Patient Satisfaction with Nursing Care Quality Questionnaire[263] Patients' Judgments of Nursing Care[264]

Process for Reviewing and Updating the Healthy Work Environments Best Practice Guidelines

The Registered Nurses' Association of Ontario proposes to update the Healthy Work Environments Best Practice Guidelines as follows:

1. Each healthy work environments best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area to be completed every five years following the last set of revisions.

2. During the period between development and revision, RNAO Healthy Work Environments project staff will regularly monitor for new systematic reviews and studies in the field.

3. Based on the results of the monitor, project staff may recommend an earlier revision plan. Appropriate consultation with a team composed of original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the five-year milestone.

4. Six months prior to the five-year review milestone, the project staff will commence the planning of the review process by:
   a) Inviting specialists in the field to participate in the Review Team. The Review Team will be composed of members from the original panel and other recommended specialists.
   b) Compiling feedback received and questions encountered during the dissemination phase, as well as other comments and experiences of implementation sites.
   c) Compiling relevant literature.
   d) Developing a detailed work plan with target dates and deliverables.

5. The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Glossary of Terms

Bullying: A form of repeated, persistent and aggressive behaviour directed at an individual or individuals that is intended to cause or ought to be known to cause fear and distress and or harm to another person's body, feelings, self-esteem, or reputation.

Consensus: A collective opinion arrived at by a group of individuals working together under conditions that permit open and supportive communication, such that everyone in the group believes she or he had a fair chance to influence the decision and can support it to others.

Correlation studies: Studies that identify the relationship between variables. There can be three types of outcomes: no relationship, positive correlation or negative correlation.

Critical reviews: Essays based on scholarship (i.e. on finding and reading the literature on a topic, and adding your own considered arguments and judgments about it). Critical reviews thus involve both review of an area, and exercising critical thought and judgment about it. Retrieved August 2, 2006, from http://www.psy.gla.ac.uk/~steve/resources/crs.html#What

Diversity: Variation between people with respect to a range of factors, such as ethnicity, national origin, race, gender, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class, or life experiences. [109]

Education recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Education program: Any organized learning experience for participants, the intent of which is to promote the development of knowledge, skills, or attitudes need a term that defines it as broader than just referring to students.

Expert opinion: The opinion of a group of experts based on knowledge and experience, and arrived at through consensus.

Healthy work environments: A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organizational performance.

Healthy Work Environment Best Practice Guidelines: Systematically developed statements based on best available evidence to assist in making decisions about appropriate structures and processes to achieve a healthy work environment.[265]

Integrative reviews: The integrative process includes (1) problem formulation, (2) data collection or literature search, (3) evaluation of data, (4) data analysis, and (5) interpretation and presentation of results. Retrieved August 2, 2006, from http://www.findarticles.com/p/articles/mi_ga4117/is_200503/ai_n13476203.

Leader: A leader is a person who influences a group of people towards the achievement of a goal.[50]

Meta-analysis: The use of statistical methods to summarize the results of several independent studies, therefore providing more precise estimates of the effects of an intervention or phenomena of health care than those derived from the individual studies included in a review.[266]

Nurses: Refers to Registered Nurses, Licensed Practical Nurses (referred to as Registered Practical Nurses, in Ontario), Registered Psychiatric Nurses, and nurses in advanced practice roles such as Nurse Practitioners and Clinical Nurse Specialists.

Organizational recommendations: Statements regarding the conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization.

Patient/Client: Recipient(s) of nursing services. This includes individuals, (family member, guardian, substitute caregiver) families, groups, populations or entire communities. In education, the client may be a student; in administration, the client may be staff; and in research, the client is a study participant.[246,267]

Patient/Client-centred care: An approach in which clients are viewed as whole; it is not merely about delivery of services where the client is located. Client-centred care involves advocacy and empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making.[98]

Practice recommendations: Statements of best practice directed at the practice of health-care professionals that are ideally evidence-based.

Qualitative research: Methods of data collection and analysis that are non-quantitative. Qualitative research uses a number of methodologies to obtain observation data or interview participants in order to understand their perspectives, world view or experiences.

Staff: The people employed in a company, school, or organization. (Retrieved from http://www.thefreedictionary.com/staff).

System recommendations: Statements of conditions required to enable the successful implementation of the best practice guideline through out the system. The conditions for success are associated with policy development at a broader research, government and system level.

Systematic review: Application of a rigorous scientific approach to the preparation of a review article.[272] Systematic reviews establish where the effects of health care are consistent, where research results can be applied across populations and settings, and where differences in treatment and effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions.[268]

Violence in the workplace: "Incidents in which a person is threatened, abused or assaulted in circumstances related to their work. These behaviours would originate from customers or co-workers, at any level of the organization. This definition would include all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery and other intrusive behaviours."(Adapted from *Canadian Healthcare Manager*. Retrieved on April 15, 2008 from www.chmonline.ca, Feb. 2007).

Workplace: In this guideline the term workplace is defined as all service and academic settings.

Zero tolerance: The policy of not tolerating violent behaviour by ensuring that swift and certain action is taken in response to incidents of violence or reports of incidents of violence. A zero tolerance policy removes discretionary power from decision-makers by making consequences mandatory. This approach supports the belief that violence is unacceptable.

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO), with funding from the Ministry of Health and Long-Term Care and in partnership with Health Canada, has embarked on a multi-year project of healthy work environments best practice guidelines development, pilot implementation, evaluation and dissemination. Expert panels convened by the RNAO, will conduct their work independent of any bias or influence from funding agencies while developing these guidelines.

In March 2007, RNAO convened a panel of nurses with expertise in practice, research, policy, education and administration who represented a wide of range of nursing specialties, roles and practice settings.

The panel undertook the following steps in developing the best practice guideline (BPG), *Preventing and Managing Violence in the Workplace:*

- The scope of the guideline was identified and defined through a process of discussion and consensus in a Scope and Purpose statement.
- Search terms relevant to workplace health, safely and well-being of the nurse were sent to a research assistant to conduct a broad review of the literature
- The panel reviewed the Organizing Framework for developing a healthy work environment and organized the concepts and content of the guideline utilizing this framework
- The panel reviewed the research assistant's report
- Supplemental literature was sourced by the panel
- Review of findings from systematic review of literature from the research assistant
- Through a process of discussion and consensus preliminary recommendations were developed based on the evidence in the literature
- Drafts of the BPG were reviewed and revised by the expert panel
- The BPG was sent out for stakeholder review
- Sub-group of the expert panel reviewed and discussed all stakeholder feedback
- Recommendations and evidence were finalized
- The expert panel reviewed and approved the final document

Appendix C: Process for Systematic Review of the Literature on Preventing and Managing Violence in the Workplace

1. A broad review of the literature using keywords associated with the definition of violence in the workplace were entered into:
   - CINAHL
   - Medline
   - PsychoInte
   - ERIC
   - Cochrane
   - Econ
   - Embase
   - PsychINFO (to June 2007)
   - Social Sciences Abstracts (to June 2007)
   - ABI Inform Global (to June 2007)

Definition of violence in the workplace: "An incident in which a person is threatened, abused or assaulted in circumstances related to their work. These behaviours would originate from customers or co-workers, at any level of the organization. This definition would include all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery and other intrusive behaviours."(*Canadian Healthcare Manager,* www.chmonline.ca, February, 2007). This includes verbal, physical, psychological, sexual and financial abuse of nurses using a broad definition of violence. It also includes policies, processes and values that perpetuate and/or support this violence.

2. The inclusion/exclusion criteria were:
   - English-only literature
   - Published within the last 10 years
   - Research papers that:
     - Define and describe forms of violence in the workplace.
     - Identify strategies to plan, implement and evaluate outcomes related to recognizing and assessing the risk of violence in the workplace, thereby fostering a healthy work environments for nurses, and support healthy outcomes for patients/clients, organizations and systems.
     - Identify individual, organizational and system resources that support recognition, prevention and effective intervention related to violence in the workplace.
     - Identify outcomes that related to the prevention and successful mitigation of violence in the workplace.

3. Search terms identified included nurse or nursing staff and each of the following terms:
   - workplace violence
   - aggression or aggressiveness in the workplace or attack behavior/ or coercion/ or conflict

- physical and abuse and physical and violence
- sexual and abuse & sexual and violence
- verbal and abuse & verbal and violence
- emotional abuse & emotional and violence
- harassment/harassing and workplace
- psychological and abuse and psychological and violence
- threat/threatening and workplace
- assault and workplace (or assaulting or assaulted)
- workplace bullying (or bullies or bullied)
- intimidation and workplace (or intimidate or intimidating or intimidated)
- interpersonal conflict
- mobbing
- horizontal violence
- worker to worker violence/abuse
- nurse to nurse violence/abuse
- client/patient to worker
- perpetrator violence/abuse
- critical incident stress management
- relationship violence
- domestic violence in workplace
- horizontal violence
- interpersonal relationships/or friendship

4. The review considered nurses in all domains (clinical practice, administration, education and research) and all sectors. The search strategy sought to find published and unpublished studies and papers within the past 10 years, limited to the English language. These papers would include controlled studies, meta-analyses, systematic reviews, descriptive correlational studies, qualitative research, integrative reviews, and critical reviews as defined in the HWE best practice guidelines:
   - Critical reviews: Essays based on scholarship (i.e. on finding and reading the literature on a topic and adding your own considered arguments and judgments about it). Critical reviews involve both reviewing an area and exercising critical thought and judgment.
   - Descriptive correlational studies: Examine and describe how variables are related to one another and are used to make predictions from present circumstances to future ones.
   - Integrative reviews: The integrative review process includes problem formulation, data collections or literature searches, evaluation of data, data analysis, and interpretations and presentation of results.
   - Meta-analysis: The use of statistical methods to summarize the results of several independent studies, therefore providing more precise estimates of the effects of an intervention or phenomena of health care than those derived from the individual studies included in the review
   - Qualitative research: Methods of data collection and analysis that are non-quantitative and which uses a number of methodologies (including interviews) to obtain observation data to understand study participants' perspectives, world view or experiences.
   - Systematic reviews: Applications of a rigorous scientific approach to the preparation of a review article. Systematic reviews establish where the effects of health care are consistent, and where research results can be applied across a population or setting, as well as differences in treatment and where effects may vary significantly.

5. Studies identified during the database search were assessed by two independent reviewers for relevance to the review, based on the information contained in the title and abstract. Disagreements between reviewers were resolved through discussion and, if necessary, input was sought from a third reviewer. One hundred and ninety-four papers that appeared to meet the inclusion criteria were retrieved and assessed once again for relevance to the review objective.

6. Identified studies that met inclusion criteria were grouped into type of study (e.g. qualitative, quantitative, non-research) then into common themes, such as training programs, or violence within specific sectors (mental health, emergency, etc).

7. Papers were summarized and assessed for methodological quality prior to inclusion in the review using an appropriate critical appraisal instrument. Non-research papers were included if they discussed the prevalence of violence or strategies to prevent or address violence in health care settings.

Results of Review

A total of 62 papers – quantitative, qualitative and textual in nature – were included in the review. The majority of papers were descriptive and examined the prevalence, antecedents and consequences of violence. Several papers also discussed the importance of training programs to help staff identify potential violent situations.

Appendix D: Risk Assessment Tools

The following examples of risk assessment tools are copyrighted and printed with permission from the Ontario Safety Association for Community and Healthcare (2006)

Appendix D–1: Key Elements–Checklist for Workplace Violence Prevention Program

How to use this checklist

Complete this checklist to summarize your organization's compliance with the key elements listed in this document.

1.1 Workplace Violence Prevention Program structure is in place

1.1.1 The organization has secured the commitment of senior management.

YES NO PARTIAL N/A

1.1.2 The organization has appointed a Program Leader.

YES NO PARTIAL N/A

1.1.3 The organization has appointed an inter disciplinary steering committee to oversee the development and implementation of the program.

YES NO PARTIAL N/A

1. 2 Workplace Risk Assessment

1.2.1 The organization has conducted an assessment of community workplace violence issues.

YES NO PARTIAL N/A

1.2.2 The organization has conducted an analysis of all internal documents reporting issues of workplace violence.

YES NO PARTIAL N/A

1.2.3 The organization has conducted an assessment of its physical environment.

YES NO PARTIAL N/A

1.2.4 The organization has conducted an assessment of the work setting and the clients.

YES NO PARTIAL N/A

1.2.5 The organization has conducted an assessment of the point-of-care work practices.

YES NO PARTIAL N/A

1.2.6 The organization has conducted an assessment of staff's perceptions of workplace violence.

YES NO PARTIAL N/A

1.3 Designing a Workplace Violence Prevention Program

Design a Workplace Violence Prevention Program that consists of a workplace violence prevention policy; reporting, response and investigation procedures; environmental control procedures, work practice and administrative control procedures.

1.3.1 The employer has developed a Workplace Violence Prevention Policy that communicates to staff that employee safety and security are as important as client safety.

YES NO PARTIAL N/A

1.3.2 The employer has developed a reporting mechanism and has trained supervisors and employees to report all incidents or accidents related to workplace violence and, where required, report accidents to the WSIB and the MOL.

YES NO PARTIAL N/A

1.3.3 The employer has developed an internal response procedure (i.e. code white, staff alert) for workplace violence where staff requires emergency assistance.

YES NO PARTIAL N/A

1.3.4 The employer has designed a process that ensures prompt and detailed investigation of violent incidents.

YES NO PARTIAL N/A

1.3.5 The employer has designed procedures to ensure environmental and security controls are implemented.

YES NO PARTIAL N/A

1.3.6 The employer has performed a risk assessment to establish comprehensive administrative and work practices and procedures to prevent workplace violence.

YES NO PARTIAL N/A

1.4 Implementing the Workplace Violence Prevention Program

1.4.1 The organization has developed a detailed plan for the implementation of workplace violence prevention program that includes marketing and communication strategies and an educational program.

YES NO PARTIAL N/A

1.5 Evaluating the Workplace Violence Prevention Program

1.5.1 The organization has developed a process to evaluate the workplace violence prevention program in consultation with the JHSC.

YES NO PARTIAL N/A

Effective Staff Training Strategies in Crisis Intervention

1.5.2 The organization uses effective training strategies to enhance employees' crisis intervention knowledge and skills.

YES NO PARTIAL N/A

Recognizing and Responding to Stages of Violence

1.5.3 Employees are trained to recognize and respond effectively throughout all phases or stages of violence.

YES NO PARTIAL N/A

Appendix D–2: Workplace Violence Document Analysis Tool

(OSACH 2006)

Date & Time	Document Type	Location	Class'n of Violence	Incident Type	Injury to Client	Details of Incident	Outcome of Incident	Outstanding Issues

Legend:

Document Type:

1. JHSC minutes
2. Security logs
3. Emergency response forms
4. Unusual occurrence reports
5. Client or visitor report forms
6. Client abuse reports
7. Grievances

Classification of Violence:

Type I: Perpetrator has no relationship to organization
Type II: Client to staff; staff to client
Type III: Worker to worker
Type IV: Personal relationship to worker (domestic violence)

Incident Type:

1. Threat
2. Physical Assault
3. Verbal Abuse
4. Discrimination/harassment
5. Carrying a weapon
6. Robbery, arson, vandalism

Appendix D–3: Unit Workplace Violence Incident or Accident Analysis Collection Tool (OSACH 2006)

Unit Name:

Date & Time	Classification of Violence					Accident Type										
	Dept	Type I	Type II	Type III	Type IV	Near Miss/ Hazard	First Aid	Medical Aid	Lost Time	Days Lost	Claim Cost	Nature of Injury	Incident Type	Location	Work Activity	Other Factors

Legend:

Classification:

Type I: Perpetrator has no relationship to organization

Type II: Client to staff; staff to client

Type III: Worker to worker

Type IV: Personal relationship to worker (domestic violence)

Accident Type

1. Near Miss/ Hazard: no employee injury/illness – potential for injury
2. First Aid: Employee incurred an injury/ illness, but did not require medical attention beyond first aid
3. Medical Aid: employee incurred and injury/illness and sought medical attention from a treating practitioner
4. Lost Time: employee lost time from work beyond initial day of accident.

Nature of Injury:

1. Strain or sprain
2. Cut or laceration
3. Contusion
4. Bite
5. Pinch
6. Psychological

Incident Type:

1. Threat
2. Physical Assault
3. Verbal Abuse
4. Discrimination or harassment
5. Carrying a weapon
6. Robbery, arson, vandalism

Location:

1. Client care area
2. Parking lot or walkway
3. Public areas on-site
4. Restricted areas on-site
5. Community
6. Client's home

Work Activity:

1. Client Care
2. Emergency response team
3. Support work functions
4. Reception work
5. Working alone in remote location
6. Communicating with family or visitors

Appendix D–4: Organizational Workplace Violence Incident or Accident Summary Tool (OSACH 2006)

Department / Unit	Type of Violence	Type I	Type II	Type III	Type IV	Type of Accident	Near Miss/ Hazard	First Aid	Medical Aid	Lost Time	Total # Accidents	Total Days Lost	Total Claim Cost	Rating compared to other Departme nt/Units

Legend:

Classification:

Type I: Perpetrator has no relationship to organization

Type II: Client to staff; staff to client

Type III: Worker to worker

Type IV: Personal relationship to worker (domestic violence)

Accident Type

1. Near Miss/ Hazard: no employee injury/illness – potential for injury
2. First Aid: Employee incurred an injury/illness, but did not require medical attention beyond first aid
3. Medical Aid: employee incurred and injury/illness and sought medical attention from a treating practitioner
4. Lost Time: employee lost time from work beyond initial day of accident.

Nature of Injury:

1. Strain or sprain
2. Cut or laceration
3. Contusion
4. Bite
5. Pinch
6. Psychological

Incident Type:

1. Threat
2. Physical Assault
3. Verbal Abuse
4. Discrimination or harassment
5. Carrying a weapon
6. Robbery, arson, vandalism

Appendix D–5: Environmental Assessment Tool (OSACH 2006)

Location	Building/Unit
Date	Time
Name of Person(s) Conducting Assessment	

Parking Lot	Yes	No	Explanation
Are the entrances and exits well marked?			
Is the lot appropriately signed with security reminders (lock car, security patrolled)?			
Is the lighting sufficient?			
Are alarms clearly marked?			
Does the lot have controlled entry?			
Are company vehicles parked on-site after hours?			
Have vehicles been stolen or vandalized on-site?			

Building Perimeters	Yes	No	Explanation
Is the workplace near any buildings or businesses that are at risk of violent crimes (bars, banks)?			
Do violent, criminal, intoxicated or drugged persons visit your building accidentally?			
Is your building located in a high crime area?			

Parking Lot	Yes	No	Explanation
Are there signs of vandalism?			
Is your building isolated from other buildings?			
Are there graffiti on the walls or buildings?			
Is the exterior of the building adequately lighted?			
Is the building entrance adequately lighted?			
If answer is no, please indicate location.			
Are garbage areas, external buildings or equipment that employees use: a) in an area with good visibility? b) close to the main building with no potential hiding places? Do overgrown shrubs or landscaping provide a hiding place?			

Natural Surveillance	Yes	No	Explanation
Are there physical objects/structures that obstruct your view?			
If yes, could someone hide behind such objects?			
If so, where? What would make it easier to see? • Transparent materials • Mirrors • Windows in doors • Angled corners • Less shrubbery • Other			

Stairwells and Exits	Yes	No	Explanation
Are stairwells and exits clearly marked, well lit, and controlled with locked doors that have panic bars to allow exit in an emergency?			
Do exit doors identify where they exit to?			
Are there places at the bottom of stairwells where someone could hide?			
Can lights be turned off in the stairwell?			
Is there more than one exit route?			
Do exit routes restrict the ability to escape an attacker?			
Do stairwell doors lock behind people during or after regular hours of operation?			

Access Control	Yes	No	Explanation
Is your building connected to other buildings through stairwells, elevators or hallways?			
If yes, is there access control to your area?			
Is there a system to alert employees to access by intruders?			
Are offices and rooms signed in all areas?			
Do you use keys or key cards to access areas?			
Is there a system in place to minimize the distribution of keys or key cards?			
Are locks replaced if keys are lost or stolen?			

Security and PA System	Yes	No	Explanation
Is there a process to call for security assistance?			
Is the security system tested monthly or annually?			
Are there security guards or safety walking services at your location?			
Where appropriate, have staff areas (e.g. emergency, reception) been equipped with panic buttons?			

Reception	Yes	No	Explanation
Is the reception or nursing station identifiable and accessible?			
Can the people at these stations see incoming visitors?			
Is the reception or nursing station visible to clients or visitors?			
Is the reception or nursing station staffed at all times?			
Can outsiders enter the ward or building if the reception or nursing station is not staffed?			
Is the reception area or nursing station the first point of contact for visitors?			
Is there a policy for receiving and identifying visitors?			
Does the area function as a security screening area?			
Does the reception or nursing station have an emergency call button?			
If yes, are response procedures developed?			
Could objects/tools/equipment in this area be used as weapons?			

Signage	Yes	No	Explanation
Immediately inside the building/ward entrance, do signs identify where you are?			
Are rules for visitors clearly signed?			
Are exit signs posted?			
Are the posted signs highly visible to all?			
Are the hours of operation adequately posted?			
Impression of overall signage: ❑ very poor ❑ poor ❑ satisfactory ❑ good ❑ very good			

Lighting	Yes	No	Explanation
List areas where lighting was a concern, i.e. too dark or too bright during the inspection			
Is the lighting evenly spaced?			
Are any lights out?			
If yes, where?			

Movement Predictors	Yes	No	Explanation
How easy would it be for someone to predict staff patterns of movement? ❑ Very easy ❑ Somewhat easy ❑ No way of knowing			
Is an alternative, well-lit and frequently travelled route available?			
Can you tell what is at the other end of each walkway or corridor?			
If no, where?			
In walkways or corridors, are there alcoves or corners where someone could hide and wait for staff?			
If yes, where?			

Elevators	Yes	No	Explanation
Do you have a full view of whether an elevator is occupied before entering?			
Is there an emergency telephone or emergency call button in the elevator?			
Is there a response procedure for elevator emergencies?			

Washrooms	Yes	No	Explanation
Is public access to washrooms controlled?			
Can the lights in the washroom be turned off?			
Are washrooms inspected on a regular basis?			
Do washrooms have emergency call buttons?			

Interview Room	Yes	No	Explanation
Do you have a separate interview/meeting room?			
If yes, is natural surveillance possible?			
Is there an alarm system in this room?			
Is the furniture arranged to allow for emergency exits?			

Pharmacy/medication room/treatment room/office	Yes	No	Explanation
Is there another way out for an emergency exit?			
Are furniture/counters arranged to allow both visibility and protection of staff?			
Do the width and height of the counter/desk provide an appropriate barrier between staff and the public?			
Does the area have an alarm system?			
Do workers sometimes work alone?			
If so, do they know emergency alert procedures?			
Is pharmacy staff required to handle cash?			

Waiting areas	Yes	No	Explanation
Does the waiting area isolate patients/clients from staff and hinder communication with workers?			
Are there objects, tools or equipment that could be used as weapons?			

Files/Records	Yes	No	Explanation
Are confidential files/records kept in a locked room?			
Are file cabinets containing confidential records locked?			

Identification system for clients and visitors	Yes	No	Explanation
Have name tags, preferably with photo and no last name, been issued to staff?			
Have tags, preferably a different colour than those for staff, been issued to visitors?			
Is there a visitors' sign-in book to document who is entering and exiting the facility?			
Have clients with a history of violent behaviour been flagged in computers, charts and wristbands?			

Individual Offices	Yes	No	Explanation
Are certain employees at higher risk of violence?			
Has office furniture been arranged: • to allow for a quick exit from the office? • to maintain a safe distance between the staff and client?			
Are objects that can be thrown or used as weapons minimized?			
Do these rooms have good natural surveillance (shatterproof glass in walls and doors)?			

Stairwells and Exits	Yes	No	Explanation
Do exits identify where they lead to?			
Do stairwells contain places at the bottom where someone could hide?			
If yes, where?			
Is the lighting adequate?			
Can lights be turned off in the stairwell?			
Is there more than one exit route?			
Do any exit routes restrict your ability to get away?			
Do stairwell doors lock behind you?			

Possible Entrapment Sites	Yes	No	Explanation
Are there unoccupied rooms that should be locked?			
If yes, where?			
Are there small, well-defined areas where someone could be hidden from the view of others? • Recessed doorways • Unlocked storage areas • Stairwells • Elevators			
Are there physical objects/structures that obstruct your view?			
If yes, could someone hide behind such objects? If so, where?			

What would make it easier to see? • Transparent material • Mirrors • Windows in doors • Less shrubbery Other:			
Do members of the public approach staff from one entrance?			

Working Alone	Yes	No	Explanation
Has an emergency contact number been established for all hours of operation?			
Are emergency telephones located in key areas, accessible to all staff?			
If no, where is access needed?			
Is there a designated "safe room" where employees can go during an emergency?			
Does this room have a telephone and a door that can be locked from the inside?			
At the time of the inspection, did any areas seem isolated?			
If yes, which areas?			
In these isolated areas, is there a telephone or a sign directing you to emergency assistance?			
In these isolated areas, how far is the nearest person who might hear calls for help?			
Do you have alarms or panic buttons (personal or stationary)?			
Are the alarms or panic buttons easily accessible?			
Do you periodically check the functioning of panic buttons or alarms?			
Is it easy to predict when people will be around?			

Appendix D–6: Community Workplace Assessment Tool (OSACH 2006)

Use this form for pre-visit assessments of violence risks. Change, delete or ignore items that are not relevant to your organization.

How a care provider approaches the client may be important for safety. Be certain to document your concerns and planned approaches, because consistency is important in minimizing risk. Your organization should decide who is qualified to make the assessment.

Take the time to contact the prospective patient or client or a family member for this information, or plan time to assess the site or area at the time of the first visit, and take the recommended precautions.

Questions about Work Environment and Client

1. What is the address and the safest route to get to client? Is the area considered a high crime area?

_____

2. What is the location of the closest and safest parking spot?
   - Park under a streetlight if working in the late afternoon or at night. Avoid night visits if possible.
   - Lock valuables in the vehicle trunk before driving away from the office.
   - Make sure the vehicle windows are closed and all vehicle doors are locked.

_____

3. Do street lamps provide enough light for walking from the parked car to the entrance, and is there a light in the entrance to the building?
   - Request that the entry area light be on, if there is one.
   - Use a flashlight if needed.

_____

4. What is the safest route into the residence, and which entrance should be used?

_____

5. Where is the nearest public phone? Are there emergency phones in the building or housing complex?

_____

6. Are staff equipped with a cell phone or two-way radios and a personal alarm? Is the area covered by cell phone service? Are cell phones pre-programmed on speed dial for 9-1-1?

7. Are there any physical hazards (barriers, broken steps, free-roaming dogs, weapons) and, if so, what is the plan for controlling these hazards during the visit?

8. If there is a possibility of encountering hazards during your visit, have you arranged for a pre-visit and post-visit call to the office, a nurse, the supervisor or, if possible, a "buddy"?

9. Will other people be in the residence during the visit? If so, how many, what is their relationship to client, is there any potential for violence, and who will open the door?

10. Is the client aware of the approximate time of your arrival?

11. During the phone interview, what is the client or family member's:
- Attitude to caregiver
- Mood
- Signs of intoxication
- Level of orientation
- Other

12. Have you reviewed the safety routine for returning to your vehicle?
- Be observant – look and listen
- Do not sling your purse or bag over your shoulder or around your neck
- Carry your keys in your hand
- Walk around vehicle, and check back seat before unlocking car
- Lock doors, keep windows up until underway

Pre-visit Assessment

Contact the referring agency for this information, and take the recommended precautions. Check each item as it is completed.

1. Do you know of any violent or aggressive behaviour by this client or other person at the worksite?

_____

2. Describe the behaviour and the frequency with which it occurs.

_____

3. Do you know of any triggers for the violent behaviour, such as when limits are set, or during specific activities?

_____

4. Is the violent behaviour directed toward a particular person or generalized, toward no one in particular?

_____

5. If directed at a particular person, what is the likelihood that this person will be in the home during a health care worker's home visit?

_____

6. Do you know of any restraining orders against anyone in the household? If yes, against whom (e.g. client, family member, or friend)?

_____

7. Have threats recently been made against the client? If so, who has made these threats? Does this person have access to the client at home?

_____

Appendix D–7: Work Setting and Client Risk Factors Checklist (OSACH 2006)

This tool can be used to help identify the risk factors that affect your workplace. Check off each risk factor that is relevant to your workplace.

Check applicable boxes

Summarize your comments in the space provided

1. **What characteristics of the worker's occupation might increase risk?**
   Note: The risk of violence is higher if the worker's occupation involves physical contact with patients or clients, particularly if the contact is frequent or prolonged. Increased risk is associated with:

Working in an emergency, psychiatric or extended-care unit	❑ Yes	❑ No
Dealing with the public (social work, nursing, human resources, reception)	❑ Yes	❑ No
Dispensing drugs	❑ Yes	❑ No
Delivering social services	❑ Yes	❑ No
Handling cash	❑ Yes	❑ No
Working alone (or in a small group), at night, or during early morning hours	❑ Yes	❑ No
Performing public health or security functions	❑ Yes	❑ No

Comments:

a) What aspects of the workplace environment might increase the risk of violence?

Working alone or in remote locations	❑ Yes	❑ No
Working in the community in areas with high crime rates and/or gang-related problems	❑ Yes	❑ No
Clinic staff who stay behind after regular office hours, or use weekends to catch up on work	❑ Yes	❑ No
Needle-exchange workers	❑ Yes	❑ No

Social workers, home support workers, nurses and other health care providers who travel by car, bus or on foot between clients' homes ❑ Yes ❑ No

Night-shift health care workers who work alone ❑ Yes ❑ No

Interconnected buildings and shared premises that may allow members of the public uncontrolled access to, or increased movement between, facilities ❑ Yes ❑ No

Care areas such as emergency, critical care or pediatric wards, which tend to be very stressful for the patient or client and family members ❑ Yes ❑ No

Areas with public waiting areas (lobbies, emergency departments and ambulatory clinics) where long waiting periods and crowded conditions can contribute to the incidence of disagreements or brawls ❑ Yes ❑ No

Other (specify)

Appendix D–8: Checklist of Risk Factors for Aggressive Behaviour (OSACH 2006)

Client Factors

- ❑ Language or cultural barriers
- ❑ Diagnosis (psychogeriatric illness, mental illness, medical condition)
- ❑ Poverty
- ❑ Fear
- ❑ Loss of control
- ❑ Loneliness
- ❑ Frustration
- ❑ Boredom
- ❑ Effects of medications or lack of medication
- ❑ Anniversary of a significant event
- ❑ Losses (friends, family, no support system)
- ❑ Lack of information
- ❑ Time of day or week ("sundown syndrome")
- ❑ Task too complicated
- ❑ Physiological needs (fatigue, hunger, need to void)
- ❑ Reaction to race and sex of caregiver

Caregiver Factors

- ❑ Unpredictable work load
- ❑ Lack of training
- ❑ Time of day (mealtime)
- ❑ Day of week
- ❑ Working alone, especially at night
- ❑ Geographic isolation (difficulty in getting help quickly)
- ❑ Stress
- ❑ Lack of staff (clients have to wait for care or attention)
- ❑ Worker unaware of client's history of abusive behaviour
- ❑ Worker unfamiliar with client (staff rotation or change of staff)
- ❑ Uniform, appearance, religious jewellery
- ❑ Infringement on personal space
- ❑ Need to physically touch to provide care

- ❑ Body language
- ❑ Inconsistent handling
- ❑ Hurried approach
- ❑ Level of authority
- ❑ Regimented client care schedule

Environmental or Ergonomic Factors

- ❑ Colour (cool colours are calming)
- ❑ Too much noise
- ❑ Lighting (too much glare on the floors or a lack of visual contrast may confuse cognitively impaired clients; too little light (for example, dark parking lots in isolated areas, underground, not supervised)
- ❑ Lack of space and privacy
- ❑ Lack of, or improper, communication systems
- ❑ Temperature (too hot, too cold)

Appendix D–9: Point–of–Care Staff Work Practice Assessment

(OSACH 2006)

- ❑ You consider the client's wishes and needs when establishing a client care plan.
- ❑ The client history includes the likelihood of a client exhibiting aggressive or violent behaviour.
- ❑ There is a process to tag or flag clients who are potentially aggressive and/or violent. It considers such factors as personality, medications, type or degree of illness and history. Patient confidentiality is balanced with employee safety.
- ❑ Your organization supports a flexible care plan designed to meet the needs of your clients.
- ❑ There are certain client care activities that must be performed at a specific time of day.
- ❑ There is a standard assessment conducted on a client that determines the likelihood of an aggressive response.
- ❑ You consider staff safety when designing a client care plan.
- ❑ You explain to a client what you are going to do and how you are going to do it each time you engage in a client care activity.
- ❑ The client is kept informed about treatment, procedures and care planning.
- ❑ The client's privacy and dignity are respected during care activities.
- ❑ Client assignments need to be completed by one person working in isolation. Can the job be done more safely with two people working together?
- ❑ Clients' scheduled appointments are kept promptly.
- ❑ Staff breaks are scheduled outside client meal times when client needs are high.
- ❑ All staff are educated in recognizing escalating behaviour and patterns of violence.
- ❑ All staff are educated in effective communication techniques.
- ❑ There is an effective emergency response mechanism that staff can readily access in an emergency situation (i.e., code white, panic button).
- ❑ There is a process for restricting visitors with a history of violence.
- ❑ Staff can review a client's profile before meeting with that client.
- ❑ Regular case management meetings are held with all staff who are directly or indirectly involved in the care of potentially violent patients or clients. Ways to deal with these patients or clients are discussed and client care plans updated to indicate factors that trigger violence and suggest controls.
- ❑ Potentially violent patients are segregated in more secure or restrictive settings, if possible.
- ❑ Staff who are more experienced or staff who have a demonstrated ability to handle potentially violent situations are assigned to high-risk areas or to high-risk clients.
- ❑ Before approaching a client, you make sure that the lighting is adequate.
- ❑ A comfortable temperature and low noise levels are maintained.
- ❑ If patients resist or become hostile during care, the care is stopped immediately.
- ❑ If you feel threatened in any way during client care, there is a process to request the presence of another staff member.
- ❑ There is a process to prohibit staff from working alone in emergency areas or walk-in clinics, especially at night or when assistance is unavailable.
- ❑ There are lock-up procedures for pharmaceuticals

Appendix D–10: Workplace Violence Employee Survey (OSACH 2006)

Do you feel safe while at work?	❑ Yes	❑ No	
Do you think you are prepared to handle a violent situation, threat, or responsive and escalating behaviours exhibited by clients while at work?	❑ Yes	❑ No	
In your opinion, has the employer provided you with every necessary control and measure to protect your safety?	❑ Yes	❑ No	

If you answer no, check areas that require improvements:

Lighting	❑ Yes	❑ No	❑ N/A
Secure areas to store personal belongings	❑ Yes	❑ No	❑ N/A
Security personnel	❑ Yes	❑ No	❑ N/A
Secure restrooms	❑ Yes	❑ No	❑ N/A
Secure parking lot	❑ Yes	❑ No	❑ N/A
Restricted public access to work areas	❑ Yes	❑ No	❑ N/A
Patient or client transfers – violence-related	❑ Yes	❑ No	❑ N/A
Information about security devices (e.g. cameras, alarms, panic buttons, etc.) is clearly communicated to all employees	❑ Yes	❑ No	❑ N/A
Appropriate security devices (e.g. panic buttons, personal alarms, cell phones)	❑ Yes	❑ No	❑ N/A
Communication about the care plan and the client's previous history of violence or behavioural issues	❑ Yes	❑ No	❑ N/A

Comments:

_____

_____

If you work in the community, are you provided with any of these supports?
(Add any other supports you think would help safeguard your security)

The assistance of a buddy or security guard in high-risk situations	❑ Yes	❑ No	❑ N/A
A cell phone or radio when needed	❑ Yes	❑ No	❑ N/A
A security contact person	❑ Yes	❑ No	❑ N/A
The information you need about the patient or client	❑ Yes	❑ No	❑ N/A
The information you need about the geographical location	❑ Yes	❑ No	❑ N/A
Timely assistance when you report a problem	❑ Yes	❑ No	❑ N/A

Comments:

_____

_____

Violence Prevention Policy

Is there a written violence prevention policy for your workplace?	❑ Yes	❑ No
If yes, have you ever seen a copy of the policy?	❑ Yes	❑ No
Are there written procedures for violence prevention that deal with your work area?	❑ Yes	❑ No
If yes, are they easy to understand and follow?	❑ Yes	❑ No
Have you ever seen a copy of the procedures?	❑ Yes	❑ No

Comments:

_____

_____

_____

Incident Reporting and Follow-up

Is there a system for reporting threats and violence or aggression? ❑ Yes ❑ No

If yes, is it easy to understand and follow? ❑ Yes ❑ No

Are you required to report threats and violence or aggression? ❑ Yes ❑ No

If yes, can you do so without fear of reprisal? ❑ Yes ❑ No

Does the supervisor or manager investigate incidents without undue delay? ❑ Yes ❑ No

Does the supervisor or manager take suitable corrective action without undue delay? ❑ Yes ❑ No

Are police and emergency services called immediately when an incident involving a criminal act occurs? ❑ Yes ❑ No

Are co-workers briefed about a violent incident before coming on shift or before dealing with a previously violent patient? ❑ Yes ❑ No

Is there a program to provide support for workers both directly and indirectly involved in events of workplace violence (critical incident stress management)? ❑ Yes ❑ No

When an incident of workplace violence has resulted in you seeking medical attention or losing time from work, has the employer reported the incident to WSIB? ❑ Yes ❑ No

Comments:

_____

_____

Education and Training

Have you received training in recognizing, preventing and dealing with workplace violence? ❑ Yes ❑ No

Have you received training in psychiatric, behavioural and physiological conditions associated with escalating behaviours? ❑ Yes ❑ No

Have you received training in self-defense measures that are respectful to the clients you are caring for? ❑ Yes ❑ No

Have you received training in communication and care strategies? ❑ Yes ❑ No

If yes, do you feel that training was adequate? ❑ Yes ❑ No

Is your training tailored to the particular job that you do? ❑ Yes ❑ No

Do you know what protocols (policies and procedures) exist in your workplace to deal with violence and its consequences? ❑ Yes ❑ No

Do you know what standard of care your employer expects you to deliver when a patient or client is abusive or threatening toward staff? ❑ Yes ❑ No

Comments:

_____

_____

Incidents at Work

Have you ever been the victim of a violent incident on the job?
If yes, please answer these questions: ❑ Yes ❑ No

Type of incident(s) (describe)

_____

Were you injured? (If yes, describe injuries) ❑ Yes ❑ No

_____

Did you receive first aid or medical treatment? Did you lose time from work? ❑ Yes ❑ No
If yes, describe:

_____

Did you report the incident to the employer? If you received medical attention or lost time, was the event reported to WSIB? ❑ Yes ❑ No

Were you offered defusing (an opportunity to express your thoughts about the incident, and learn about normal stress reactions and available services)? ❑ Yes ❑ No

If yes, was it done? ❑ Yes ❑ No

Were you offered Critical Incident Stress Management debriefing (a discussion with a facilitator to alleviate trauma and speed up your recovery) within 24 to 72 hours? ❑ Yes ❑ No

If yes, was it done? ❑ Yes ❑ No

In your opinion, what steps could be taken to make your workplace safer?

_____

_____

_____

Appendix D–11: Workplace Violence Prevention Risk Assessment Summary and Action Plan (OSACH 2006)

Risk Assessment	Location	Description	Category of Violence	Degree of risk	Recommended Actions	Responsibility	Date
Community							
Internal Document Review							
Employee Incidents or Accidents							
Physical Environment							
Work Setting and Clients							
Point-of-Care Work Practices							
Employee Perception							

Review the seven completed risk assessments (community, internal documents/employee incidents, physical environment, clients, point-of-care, work practices, employee survey) and summarize findings.

Legend:

Category:

Type I (Criminal Intent): committed by a perpetrator who has no relationship to the workplace

Type II (Client or Customer): perpetrator is a client at the workplace who becomes violent toward a worker or another client

Type III (Worker-to-worker): perpetrator is employee or past employee of the workplace

Type IV (Personal Relationship): perpetrator usually has a relationship with an employee (e.g. domestic violence in the workplace)

Location:

On-site – specify area

Off-site – specify (client home, travel)

Degree of Risk:

(Consider frequency, severity):

1. high
2. moderate
3. low

Appendix D–12: Workplace Violence/Client Aggression Event Report Form and Investigation Tool (OSACH 2006)

PART 1 - EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)		
Name		Position
Dept./Unit		Shift
Date and time of incident		
Date and time incident reported		
Incident reported to		
Location of incident		
❑ client care area	❑ public area on-site	❑ restricted area on-site
❑ parking lot or walkway	❑ community	❑ client's home
Work location if off-site		
Were the emergency response measures initiated? ❑ Yes ❑ No		
Please indicate the classification of the incident (please refer to explanation provided)		
❑ Type I (Criminal Intent)	Person has no relationship to the workplace	
❑ Type II (Client or Customer)	Person is a client, visitor or family member of a client at the workplace who becomes violent toward a worker or another client; or worker becomes violent toward a client, visitor or family member of a client	
❑ Type III (Worker-to-worker)	Perpetrator is an employee or past employee of the workplace	
❑ Type IV (Personal Relationship)	Perpetrator usually has a relationship with an employee (e.g. domestic violence in the workplace)	
Describe the event including persons involved		
Does the person involved have a history of previous incidents? ❑ Yes ❑ No ❑ Don't know		
Incident Type		
❑ Threat	❑ Physical assault	❑ Verbal abuse
❑ Discrimination or harassment	❑ Robbery, arson, vandalism	❑ Carrying a weapon

Injury Type		
❑ Strain or sprain	❑ Cut or laceration	❑ Contusion
❑ Bitten	❑ Pinched	❑ Psychological
Other (specify)		
Was medical attention or first aid required?	❑ Yes	❑ No
If yes, provide details		
Description of incident (Please describe what happened in the space below)		
Who was involved?		
What events lead up to the incident?		
Were other individuals involved? (e.g. staff, visitors, clients, etc.)		
What precipitated the incident?		
Other		
Actions taken		
Please indicate concerns, issues and actions taken (e.g. initiated emergency response plan, contacted supervisor, police or security, emergency service personnel, etc.)		
Witness(es)		
Name	Contact information	
1.		
2.		
3.		
4.		
Other Information		

Are you aware of any similar incidents in the past?	❑ Yes ❑ No
If yes, provide details:	
Are you aware of any controls, measures or procedures to prevent a similar incident?	❑ Yes ❑ No
Please provide any other information you think may be relevant, including any recommendations that you think would be helpful:	
Reporting	
Reported to supervisor?	❑ Yes ❑ No
If yes, name of supervisor	
Reported to police?	❑ Yes ❑ No
If yes, police report number	
Reported to human resources?	❑ Yes ❑ No
If yes, name of human resources personnel	
Reported to WSIB (Form 7)?	❑ Yes ❑ No
If yes, by whom?	
Modified work offered?	❑ Yes ❑ No
If yes, describe	
Signature of worker	
Signature of supervisor	

PART 2 - SUPERVISOR'S REPORT (TO BE COMPLETED BY SUPERVISOR)	
Name	Position
Date reported	Date of investigation:
Security contacted	❑ Yes ❑ No
If yes, how? By whom?	
Was security obtained? Did they respond immediately?	❑ Yes ❑ No
If yes, by whom?	
Police contacted?	❑ Yes ❑ No
If yes, by whom?	
Human resources contacted?	❑ Yes ❑ No
If yes, by whom?	
Persons participating in investigation	
Description of findings (Identify immediate cause, underlying cause)	
Witnesses and statements	

Corrective action taken or recommendations for corrective action

Post-crisis intervention	
Referral to employee assistance program or other community resource?	❑ Yes ❑ No
Critical Incident Stress Debriefing where required?	❑ Yes ❑ No
Advised to consult a physician for treatment or referral?	❑ Yes ❑ No
Follow-up	

Appendix D–13: Environmental Control Procedures Checklist

(OSACH 2006)

Building Security

- Install 24-hour closed-circuit video recorders for high-risk areas. If closed-circuit TVs are monitored, they can reduce crime, particularly if perpetrators know that they are being monitored.
- Alert the public that cameras are being used. Install signs: for example, "This area is monitored 24 hours per day by video surveillance cameras."
- Place surveillance cameras and telephones to strategically complement natural surveillance.
- Restrict building access, especially at night or on weekends.
- Install alarm systems or panic buttons in areas where risk factors are present: for example, human resources units, mental health clinics, emergency or urgent care units, drug dispensing areas, patient accounts counters and psychiatric units. Systems or buttons should not be installed in obvious locations such as desks or counters. Ensure that the triggers are accessible to the employee and not to the public.
- Train, and regularly test, staff in the use of the alarm system. A trained response team should be available 24 hours per day.
- Install telephones in isolated areas.
- Secure electrical panels, communication panels and elevator controls against unauthorized access.
- Where risk is anticipated, provide staff with lightweight, easy-to-use devices such as hand-held alarms, cell phones or private-channel radios. Ensure that there is a reliable system to respond to alarms.
- Use coded cards or keys to control access to the building or within the building. Limit the number of keys and entry cards distributed. If a key or card is lost, change the entry card codes and locks immediately.
- Practise response drills monthly.

Site Design and Environment

- Do a security audit for approaches to the building, path to the parking lot, etc.
- Assess plans for new construction or renovations to eliminate or reduce security hazards.
- Design counselling, client intake and treatment rooms with two exits if possible.
- Provide employees in high-risk areas with "safe rooms" for use during emergencies.
- Provide a separate, lockable, secure bathroom for employees with access to alarm/security.
- Provide employees with a locked, secure area to store personal belongings.
- Keep the building well-maintained and free from garbage and graffiti.
- Install clear, concise, highly visible and readable signage.
- Avoid positioning expensive equipment, such as computers, near ground-floor windows.

Lighting

- Illuminate all publicly accessible spaces to a minimum of 4.0 foot-candles unless otherwise specified in the Ontario Building Code. Place lights to maintain consistent illumination and to minimize contrast between light and shadow.
- Use light colours for perimeter walls in interior public spaces. Such colours improve visibility and maintain light levels.
- Locate light fixtures to illuminate pedestrian routes and spaces with special emphasis placed on illuminating possible entrapment spots.
- Replace all burned-out lights immediately.

Furniture

- Keep furniture in waiting rooms, treatment rooms and intake areas to a minimum. The furniture should be lightweight and without sharp corners or edges, or it should be secured to the floor. Avoid ornaments or pictures that could be used as weapons.
- Arrange furniture in all client areas to prevent entrapment of staff.
- Implement a retail tagging system to protect equipment.
- Organize workstations to minimize physical contact with clients.

Entranceways and Hallways

- Design entrances and exits in a manner that discourages the public from using side or back entrances.
- Lock all unused doors, within local fire code parameters, to limit access.
- Where possible, install windows or glass doors for greater visibility.
- Eliminate hidden corners.
- Place curved or circular mirrors at hallway intersections.
- Keep windows and aisles clear to provide good sight lines.
- Replace all broken windows and locks immediately.
- Clearly define entrances and exits to public spaces.
- Incorporate clear safety-glass panels in all doors to stairwells, corridors and entrances so that users can see if another person is on the far side of the door.

Reception Areas and Waiting Rooms

- Clearly mark reception areas and make them easy to access. The receptionist should be able to see incoming and outgoing traffic. The receptionist's area should be locked.
- Design client service desks and reception areas with deep counters to prevent clients from touching employees.
- Have a back way out of the reception area.
- Ensure that waiting rooms are comfortable. Subdued colours and non-glare lighting can reduce stress. Sound-absorbing surfaces can minimize background noise levels.
- Allow enough personal space to keep people from feeling crowded.
- Provide entertainment and distractions for people in waiting areas. Some examples are magazines, television,vending machines and toys and books for children.
- Acknowledge clients who have been waiting a long time. Provide reassurance and explanations when possible. In the event of long delays, allow people to reschedule appointments.
- Provide a separate waiting area to isolate certain individuals, as required.

Nursing Stations

- Consider the installation of security measures. Ideally, security measures should be considered during the planning process for new construction or renovations.
- Enclose nursing stations in shatterproof glass to prevent patients from reaching in or throwing objects at nurses.
- Have a back way, or at least a second way, out of the nursing station.
- Install alarm systems that detect unlawful entry or attempts at vandalism.
- Secure medical files, medications, narcotics and medical supplies in locked storage rooms.

- Secure medical equipment and other valuable items in locked storage after hours.
- Inform patients or clients of these control measures to deter them from attempting to steal or vandalize.

Grounds and Parking Lot Design

- Locate parking lots within direct view of the building to maximize the visual connection between the building and the parking lot. If these must be located behind a building, it is best to position them next to another public space or parking lot. Windows overlooking or doors opening onto parking lots increase visibility and, hence, safety.
- Illuminate parking areas and entrances at night.
- In enclosed parking spaces, use columns instead of solid walls for structural support.
- Clearly mark all entrances and exits of both parking and walking areas.
- Use bright, effective lighting and replace burned-out lights immediately.
- Post signs that remind users to lock their vehicles and to remember their level and aisle location.
- Use pass cards to control access to the parking lot.
- Post "No Trespassing" and "Security Patrolled" signs where applicable.
- Paint underground parking lot walls white to increase the light level, to minimize hiding areas and to maximize visibility.
- Establish a clear division between employee and visitor parking.
- Do not allow parking lot doors that open onto the street to be propped open. Doors that open onto a common area ... are preferable as they are not easily accessed by outsiders.
- Clearly mark alarms and provide zone locations at alarms so that security personnel can respond quickly.
- Link emergency doors to alarms.
- Install speed bumps in traffic lanes near exits, drive-up windows and along pedestrian routes.
- Have security staff patrol at variable times and over variable routes.
- Provide employees with a parking lot escort after hours.
- Use cameras for electronic surveillance wherever possible.
- Use strategically positioned fences to control access to the grounds.
- Locate special-purpose areas that employees must access—such as garbage disposal, annexes and equipment storage—close to the main building. The areas should be well-lit with good lines of sight from the main building.
- Avoid using canopies, shelters and awnings that block the line of sight and compromise building security. Avoid installing canopies where undesirable loitering can become a problem.
- Eliminate all unnecessary corners, planters, walls and fences that could be entrapment spots, especially near entrances and exits.
- Because shrubbery can create hiding places, keep it low and trimmed away from doors, windows and lighting. Keep vegetation close to pedestrian pathways low. Remove or trim overgrown bushes or landscaping that may block the view of the parking lot, grounds or street. Trees should be trimmed of branches to a height of 1.8 m (six feet).
- Avoid using trellises or grills against buildings; they can allow someone to climb to an upper floor.
- Install motion detectors or motion-triggered lights.
- Use polycarbonate laminate film on windows to reduce window smashing.
- Install bars over windows if necessary (and if fire regulations permit).
- Maintain a record of employee licence plate numbers so that suspicious vehicles can be identified and investigated.

Appendix D–14: Preparing for a Meeting with a Potentially Violent Client (OSACH 2006)

Proper preparation can greatly decrease the risk of a violent incident with a potentially violent client. Consider these strategies before meeting with such a client:

- Gather information about the individual and his or her characteristics. If possible, find out what triggers violent behaviour in this person. Review previous reports and client files or consult with internal or external resources. Respect client confidentiality.
- Meet in as safe an area or room as possible. Consider these factors:
  a) Natural surveillance opportunities
  b) Secured furniture and absence of sharp objects or items that could be thrown or used as weapons
  c) Access to escape routes
  d) Access to panic button or alarm mechanism and telephone
- Treat or interview potentially aggressive or upset clients in a relatively open area, while observing client confidentiality and privacy.
- If you cannot choose the meeting location, bring a co-worker.
- Let security and other staff know when and where you are meeting.
- Ask a co-worker to telephone you at a predetermined time during the meeting. Give "yes" or "no" answers to pre-planned questions such as:
  a) Are you okay?
  b) Do you need me to join you?
  c) Do you want me to call security or the police?
- Give the client copies of documents so that you can keep your distance.
- Be on time; waiting can trigger anger.

Body Language

Employees must pay close attention to the body language of a potentially violent client. A hostile stance increases tension and interferes with verbal communication. When approaching an angry person:

- Stand about one metre (three feet) away (that is, outside the individual's personal space), on an angle (as opposed to . directly in front of the person) and on the person's non-dominant side (people usually wear watches and part hair on the non-dominant side)
- Place yourself so that you have a clear exit
- Position yourself on the same physical level; avoid standing over the person
- Use calm body language: hands open, attentive facial expression, relaxed posture
- Avoid pointing or gesturing; make no sudden movements
- Avoid touching the person
- Avoid staring eye contact

Verbal Communication

Talking can defuse anger. Here are some strategies to use when speaking with someone who is angry:

- Make your first contact neutral or non-directive: for example, ask how you can help. This inquiry communicates a sense of normal interaction.
- Always be courteous to clients despite their behaviour. Introduce yourself and call them by name.
- Use active listening skills. Do not interrupt.
- Confirm your understanding of the issue or problem by repeating what the client has told you.
- Acknowledge the client's feelings and concerns.
- Use simple language; avoid jargon or technical language.
- Speak slowly, quietly and confidently.
- Remain open-minded and objective.
- Always be honest. Do not make promises that you cannot keep.
- Keep the client's attention focused on the current issue.
- Use silence as a calming tool.
- Always attempt to explain delays or long waiting periods. Not doing so can be construed as discourtesy.
- Be prepared to apologize as necessary and accept criticism positively.
- Avoid giving commands.
- Look for ways to the help the person save face.
- In a calm and non-threatening way, explain that violence is unacceptable and is not tolerated.
- If you feel threatened, politely and calmly terminate the interaction.

Terminating an Interaction with an Angry Client

If you feel threatened, or if the interaction is increasing a client's anger, terminate the interaction immediately.

- Calmly but politely interrupt the conversation.
- Tell the person that the conversation is over.
- Either leave or ask the person to leave.
- If the person does not leave, inform a manager or supervisor immediately.
- Notify other staff in the immediate area.
- If required, call the emergency response team. Consider using a silent alarm or code word if your organization uses these.
- Call the police.
- If you threaten to call the police, be prepared to call them.
- Complete an incident report after the employee has received treatment.

Appendix D–15: Work–related Travel Procedures (OSACH 2006)

Planning Travel

Whether travelling by car or public transit, workers are responsible for planning ahead.

- Get to know the area, particularly the safe area in the district. Plan the route and method of travel well in advance. Have insurance if travelling by car. Keep pertinent telephone numbers (e.g. destination, taxi service, hotel, rental car agency, reliable tow truck company, etc.) handy.
- Avoid driving in isolated or dangerous areas. Plan the safest route to and from the client's home, even if it isn't the most direct. If travelling through dangerous areas is unavoidable, travel with a companion and note nearby police stations, public telephones and other public buildings like hospitals and restaurants or stores that remain open late.
- If possible, arrive during daylight hours.
- Carry a cell phone.
- Always be aware of your surroundings.
- Wear comfortable, conservative clothing and shoes with non-skid soles. Do not wear expensive jewellery or show large amounts of money. Religious symbols should be worn discreetly. Avoid earrings or accessories that could be grasped or pulled by another person. Do not wear headphones.
- During the day, apply broad-spectrum sunscreen with a minimum 15 SPF and wear sunglasses, long sleeves, etc., to reduce UV exposure when driving.
- Keep money in an accessible pocket to eliminate searching through a purse or wallet.
- Advise your home and office when you arrive.

Travelling by Public Transit

- Walk confidently with head erect.
- Keep an up-to-date transit schedule in an easy-to-access location.
- Have the exact change ready in a pocket. Avoid opening your purse or wallet.
- If possible, travel during the day.
- Always wait at a designated transit stop. Stand with a group of people rather than alone.
- Stand away from the edge of the subway platform and use the alarms in the subway, bus, streetcar as necessary.
- Stand or sit near the driver or streetcar operator or in the Designated Waiting Area of the subway platform.
- If someone is bothering you, or if you feel threatened, let the driver know immediately.
- Move instantly if jostled – it helps to foil pickpockets.
- Always be aware of your surroundings.
- Avoid direct eye contact with other travellers and do not participate in lengthy conversations with people in the street.
- If you suspect you are being followed, try to get back on the transit system or walk directly to a store or business and call 9-1-1. In a neighbourhood, go up to the nearest lighted house and walk in or ask to be let in.
- If taking a taxi, check that the driver's identification and photo are clearly displayed and match the driver. Sit behind the front passenger seat. State the route you prefer, sticking to the main streets. State that someone is waiting for you. If you become uneasy with the driver, request that he or she pull over and let you out.

Travelling by Car

Workers are responsible for ensuring that their cars are road-ready by servicing them regularly (we recommend every six months). They are also responsible for employing safe driving practises, such as getting snow tires in winter or using four-wheel drive in the far north.

Winter Car Survival Kit

In the trunk:

- Axe or hatchet
- Booster cables
- Cloth or paper towels
- Compass
- Emergency food pack
- Extra clothing/footwear
- Fire extinguisher
- Ice scraper and brush
- Matches, survival candle in a deep can
- Methyl hydrate (for fuel line and windshield de-icing)
- Road maps
- Sand, salt or kitty litter
- Shovel
- Tow chain
- Traction mats or "ladder"
- Warning light or road flares
- Safety vest
- Work gloves

In the car:

- Flashlight
- First-aid kit
- Survival blanket
- "Call Police" sign: durable, reflective plastic sign that hooks on the window and is visible from both directions at any time during any weather

Vehicle check-list

- Use steel-belted radial tires to reduce the chance of a flat tire and keep the tires properly inflated.
- Check windshield wiper fluid level, battery and lights.
- Keep the gas tank more than half full at all times.

Safe-driving practices

- Always approach your car with your car keys already in hand. Hold one key between your thumb and first finger so that the key can be used to as a weapon to protect yourself. Having your keys in your hand also allows you to quickly enter your car.
- In above-ground parking lots, park in well-lit areas near the main entrance or exit to the building.
- In underground parking lots, back into the parking space so you can leave the parking lot area quickly and safely.
- Check underneath the vehicle as you approach to make sure no one is hiding there, then check the back seat before getting into your car. If you notice someone near, at or in your vehicle, go to a safe area and contact security or the police.
- Keep the car doors locked and the windows closed when parking.
- Keep the doors locked when travelling in your car.
- Always use seat belts.
- Refrain from using the cell phone while driving. Pull off the road to make a call and limit phone use to emergencies. Consider using a head set or speaker phone in the car.
- Refrain from smoking in the car. Cigarette smoke leaves a film on windows and nicotine and carbon monoxide can reduce night vision.
- Do not wear sunglasses at night: they do not reduce headlight glare.
- Switch from high beams to low during night driving when within 150 m (500 feet) of an oncoming vehicle, or approaching within 60 m (200 feet) of turns and the crest of hills on country roads.
- Develop a routine for looking ahead, from side to side and in the rear view mirror. Check mirrors every five to 10 seconds and always before stopping or changing lanes. Always check blind spots by turning your head when changing lanes.
- Move away from drivers who are driving erratically.
- In traffic queues, stop when you can still see the wheels of the car ahead. Put your foot firmly on the brake when you stop. At that distance, you can always get your car out of the queue and you have a buffer if hit from behind.
- If you suspect that you are being followed, note the car's licence number and go immediately to a police, fire or service station. Do not leave the car, but honk your horn repeatedly until someone responds. Do not go home.
- If you are driving to a client's home, avoid parking directly in front of the home. Park next door so that you can see the front and sides of the dwelling as you approach.
- Roll up the windows and lock the car.
- Don't leave personal or nursing items visible. Leave purses at home and carry identification and money in front pockets. Post a sign on the dashboard stating that no drugs or equipment are inside the car.
- Park in open areas. Avoid underground parking garages. If you must use one, park near an exit in a well-lit area. Back into the parking spot and take a few minutes to observe the surroundings. Avoid parking beside a van or other large vehicle where you could be wedged in.
- If your car breaks down, try to get it to the side of the road. Put on the emergency flashers. Do not get out of the car. Keep the doors locked and the windows closed. Use your cell phone to call for assistance. If you do not have a cell phon, place a "Call Police" sign on the windshield. If someone other than a police officer comes to the car to assist you, open the window no more than 2 cm (1 inch) to speak to them. Do not accept help from a stranger. Ask the person to call the police or a towing service.

Winter Driving Tips

- Contact the Ontario Provincial (OPP) or Ministry of Transportation to obtain current road conditions in the destination area.
- Reschedule your appointment, if necessary.

- Clear snow from the hood, roof, windows and lights.
- Slow down gradually when driving into a patch of fog. Keep low beams on and turn on the defroster to improve visibility.
- Stay a safe distance from the vehicle ahead. A safe following distance, in good conditions, is at least three seconds behind the vehicle in front. Increase the distance during bad weather and when following large vehicles that block the view of the road ahead.
- Keep to main roads.
- Wear warm clothing that does not restrict movement.
- Tune the radio to receive weather advice.

What to Do if Confronted by an Aggressive Driver

- Avoid eye contact and refrain from exchanging words or gestures and from retaliatory driving manoeuvres.
- Stay in control. Allow the driver to pass. Drop back and let them get far ahead.
- If pursued, go directly to a nearby safe area or police station.
- Use a cell phone to call for help.

Parking Lot Safety Tips

- If possible, park on the premises rather than on the street.
- Walk confidently with head up and be aware of your surroundings.
- Park as close to the building as possible, especially during the evening or night. Some employers have reserved parking spaces for evening and night shift workers. If you are parked far away, go out during the afternoon and move your car closer to the building.
- Know where emergency telephones are.
- Look around before leaving your vehicle.
- Avoid leaving valuables inside your vehicle.
- Avoid locking your purse in the trunk of your vehicle.
- Use the main entrance; avoid rear or secluded entrances.
- Put your keys in your hand before leaving the building and carry a whistle or another type of personal alarm.
- During the late evening and night hours, have security escort you to your vehicle. If they can't escort you, use the buddy system. If you must walk alone, have someone watch you from a door or window.
- If you notice someone loitering near your vehicle, do not go to your vehicle; go to a safe area and contact security or the police.
- When approaching your vehicle, check underneath from a distance to ensure no one is hiding there or behind the vehicle.
- Look inside your vehicle before getting in.
- Once inside your vehicle, lock all doors and keep all windows up.

Staying at a Hotel

- Choose a hotel in a safe neighbourhood.
- Choose a hotel with extra security measures such as doors equipped with peepholes, dead bolts and chain locks.
- Request a room without a connecting door and away from the fire exit or stairwell.
- Once in the room, close and lock all doors and windows. Keep draperies and blinds closed.

- Tell the desk attendants not to give your name or room number to anyone.
- Have all deliveries made to the front desk and not to the room.
- When you leave the room, leave the lights on and leave open the closet door, bathroom door and shower curtains. When you return, leave the room immediately if anything has changed. Go to the reception desk and request a security check of your room.
- Call the front desk to confirm the identity of anyone knocking on your door. Do not open the door for people claiming to be hotel maintenance, security, etc., without first confirming their identity.

Appendix D–16
Sample Terms of Reference – Workplace Violence Prevention Multidisciplinary Committee

Goals:

- To support the organization's goal of increased staff and client safety by reducing the risks of acts of workplace violence
- To provide the best quality of care to clients by supporting a caring and gentle approach to dealing with responsive behaviours (client aggression)
- To provide a safe working environment, thereby reducing the number and severity of staff incidents or accidents related to workplace violence
- To raise awareness of risks of workplace violence among all stakeholders

Purposes of the committee:

- To conduct a risk assessment of organizational factors related to workplace violence
- To develop policies and procedures related to workplace violence prevention
- To identify desired outcomes based on policies, procedures and best practice
- To participate in the selection of control measures
- To assess learning needs of staff related to workplace violence prevention
- To develop a training program for employees based on the learning-needs assessment and desired outcomes
- To coordinate the implementation of the training program for staff
- To conduct an evaluation of the training program based on the desired outcomes

Accountability:

The committee is accountable to the senior team through the Workplace Violence Prevention Program leader. The committee provides timely progress reports to the senior team, the joint health and safety committee, and other committees deemed appropriate by the organization (e.g. quality practice committee).

Membership:

- Senior management
- Program Leader
- Educator or clinician
- Managers, supervisors
- Front-line staff
- JHSC
- Union representation
- Communications or PR support
- Security personnel (if applicable)
- Social worker
- Environmental or plant maintenance

Quorum: a majority of members

Meetings: monthly and as required, at the call of the chair

Agenda and minutes:

- Circulate an agenda before each meeting of the committee.
- Distribute minutes of the meetings to members after each meeting.
- Copy minutes to senior team members and other clinical or services leaders as designated by the organization.
- Give minutes of the meeting to the JHSC.

Appendix D–17: Sample Workplace Violence Prevention Policy

(Name of Organization)

Mission

(Name of organization) is committed to providing a safe, healthy and supportive working environment by treating our employees and clients with respect, fairness and sensitivity. Violence in the workplace can have devastating effects on the quality of life for our employees and on the productivity of the organization.

Purpose

(Name of organization) is committed to the prevention of workplace violence. The purpose of this policy is to define behaviour that constitutes workplace violence and to define procedures for reporting and resolving incidents of workplace violence. (Name of organization) is committed to providing a working environment free of violence by ensuring that all workplace parties are familiar with the definitions of workplace violence and their individual responsibilities for prevention and corrective action. To establish this policy, (Name of organization) has consulted the joint health and safety committee and the following legislation governing workplace violence in Ontario:

- The *Occupational Health and Safety Act*
- The *Criminal Code of Canada*
- The *Ontario Human Rights Code*
- The *Workplace Safety and Insurance Act, 1997*
- The *Compensation for Victims of Crime Act*
- The *Regulated Health Professions Act*

Policy Statement

The management of (Name of organization) recognizes the potential for violence in the workplace and therefore will make every reasonable effort to identify all potential sources of violence to eliminate or minimize these risks through the Workplace Violence Prevention program. (Name of organization) refuses to tolerate any type of workplace violence, within the workplace or at work-related activities. (Name of organization) is committed to the expenditure of time, attention, authority and resources to the workplace parties to ensure a safe and healthy working environment for all employees and clients for whom we provide care.

For the purpose of this policy, "violence" is any actual, attempted or threatened conduct of a person that causes or is likely to cause physical and/or psychological harm/injury/illness or that gives a person reason to believe that s/he or another person is at risk of physical or psychological harm/injury/illness, including, but not limited to, any actual or attempted assault (including sexual assault and physical attacks); threat; verbal, psychological or sexual abuse; and harassment.

Definitions Associated with Workplace Violence

- Assault: any intent to inflict injury on another, coupled with an apparent ability to do so; any intentional display of force that causes the victim to fear immediate bodily harm.
- Harassment: engaging in any vexatious comment or conduct that is know or ought reasonably to be known to be unwelcome, and causes the person to believe their health and safety are at risk.
- Near miss: an act of striking out, but missing the target.
- Physical attack: an act of aggression resulting in a physical assault or abuse with or without the use of a weapon (e.g. hitting, shoving, pushing, punching, biting, spitting, groping, pinching or kicking the victim, unwelcome displays of affection or inciting a dog to attack).
- Psychological abuse: an act that provokes fear or diminishes an individual's dignity or self-worth or that intentionally inflicts psychological trauma on another.
- Sexual abuse: any unwelcome verbal or physical advance or sexually explicit statement, displays of pornographic material, pinching, brushing against, touching, patting or leering that causes the person to believe their health and safety is at risk.
- Sexual assault: the use of threat or violence to force one individual to touch, kiss, fondle or have sexual intercourse with another.
- Threat: a communicated intent (verbal or written) to inflict physical or other harm on any person or to property by some unlawful act. A direct threat is a clear and explicit communication distinctly indicating that the potential offender intends to do harm, for example, "I am going to make you pay for what you did to me." A conditional threat involves a condition, for example, "If you don't leave me alone you will regret it." Veiled threats usually involve body language or behaviours that leave little doubt in the mind of the victim that the perpetrator intends to harm.
- Verbal abuse: the use of vexatious comments that are known, or that ought to be known, to be unwelcome, embarrassing, offensive, threatening or degrading to another person (including swearing, insults or condescending language) which causes the person to believe their health and safety are at risk.

Roles and Responsibilities of Workplace Parties

Employer:

- Ensure that measures and procedures identified in the violence prevention program are carried out and that management is held accountable for responding to and resolving complaints of violence.
- Ensure compliance by all persons who have a relationship with the organization, such as physicians, contractors, volunteers, etc.
- In consultation with Joint Health Safety Committee (JHSC), conduct regular risk assessments.
- In consultation with JHSC, establish control measures.
- In consultation with JHSC, establish and deliver training and education for all employees.
- Integrate safe behaviour into day-to-day operations.
- Review all reports of violence or threats of violence in a prompt, objective and sensitive manner. This includes a review of all investigations associated with violence-related incidents.
- Take corrective action.
- Provide response measures.
- Facilitate medical attention and support for all those either directly or indirectly involved.
- Ensure any deaths or critical injuries have been reported to a Ministry of Labour (MOL) inspector, the police (as required), the JHSC, the H&S representative and trade union and investigated with the JHSC, and that a report goes to all parties in writing within 48 hours of the occurrence on the circumstances of the occurrence, including such information and particulars as the *Occupational Health and Safety Act* (OHSA) and regulations prescribe.

- Ensure a report goes to WSIB of all accidents where a worker loses time from work, requires health care, earns less than regular pay for regular work, requires modified work at less than regular pay or performs modified work at regular pay for more than seven days. Copies of accident information (where there is no critical injury) must be provided to the JHSC and trade union within four days of the occurrence, as the OHSA and regulations prescribe.

Managers/Supervisors:

- Enforce policy and procedures and monitor worker compliance.
- Identify and alert staff to violent patients and hazardous situations.
- Investigate all workplace violence using the organization's accident investigation procedure and form, and contact the police department as required.
- Facilitate medical attention for employee(s) as required.
- Ensure that debriefing is completed for those either directly or indirectly involved in the incident.
- Contact human resources to ensure the employee receives further counselling about the employee's legal rights.
- Track and analyse incidents for trending and prevention initiatives.
- Immediately report a death or critical injury to a MOL inspector, the police (as required), JHSC, H&S representative and trade union, and investigate with JHSC and report to all parties in writing within 48 hours of the occurrence the circumstances of the occurrence, including such information and particulars as the regulations prescribe.
- Issue a report to the employer and WSIB on all accidents involving lost time, where a worker requires health care, earns less than regular pay for regular work, requires modified work at less than regular pay or performs modified work at regular pay for more than seven days. Copies of accident information (where there is no critical injury) must be provided to the JHSC and trade union within four days of the occurrence, as the OHSA and regulations prescribe.
- Ensure there is a review at least annually of the workplace violence prevention program.

Employees:

- Participate in education and training programs to be able to respond appropriately to any incident of workplace violence.
- Understand and comply with the violence in the workplace prevention policy and all related procedures.
- Report all incidents or injuries of violence or threats of violence to their supervisor immediately, completing the Workplace Violence Incident Report form.
- Inform the JHSC or worker member of the JHSC about any concerns about the potential for violence in the workplace.
- Contribute to risk assessments.
- Seek support when confronted with violence or threats of violence.
- Seek medical attention.
- Participate in a review at least annually of the workplace violence prevention program.

Joint Health and Safety Committee (JHSC):

- Be consulted about the development, establishment and implementation of violence measures and procedures (the violence prevention program).
- Be consulted and make recommendations to the employer to develop, establish and provide training in violence measures and procedures.
- Take part in a review at least annually of the workplace violence prevention program.
- The worker designate should investigate all critical injuries related to violence.

- Receive and review reports of any critical injury or death immediately and in writing outlining the circumstances and particulars as prescribed within 48 hours of the occurrence.
- Review written notice within four days on lesser injuries where any person is disabled from performing his or her usual work or requires medical attention.

Reporting and Investigation

- Workers are to report all violence-related incidents or hazards to their manager or supervisor. This report can be made confidentially, at the employee's request, with the exception of the steps to ensure the safety of others and prevention of recurrence. For example, a police report may be necessary.
- The reporting worker may make the report confidentially and thus not leave a copy in the log but simply indicate the need for confidentiality to her or his direct manager or supervisor, or in the manager's or supervisor's absence, to another manager or supervisor.
- The manager or supervisor receiving the report investigates the report and ensures that measures are taken to safeguard employees and curtail the violence. No report of workplace violence or risks of violence can be the basis of reprisal against the reporting employee.
- The employer reports all injuries to the MOL and WSIB as required by the OHSA and *Workplace Safety and Insurance Act.*

Response Procedures

- The manager or supervisor documents all reports of workplace violence and hazard reporting and measures taken to address them using the incident investigation form.
- If the resolution of the incident is beyond the authority of the manager or supervisor receiving the report, they must make the CEO or equivalent aware of the report. The CEO or equivalent involves other managers or supervisors in the investigation, as appropriate (for example, when the incident involves clients or employees under another manager's or supervisor's area of responsibility).
- Management reviews all incident reports, monitors trends and makes recommendations for prevention and enhancements of the Workplace Violence Prevention Program to the CEO or equivalent.
- These findings are shared with the JHSC, which is consulted about any revision to the Violence Prevention Program and Training Program.
- The CEO or equivalent reviews reports of workplace violence and ensures that actions have been taken.
- The managers or supervisors who investigate the reported incident warn all staff who might be affected of dangerous situations. The same managers or supervisors tell the reporting employee of the outcome of the investigation enough to minimize the chance of similar incidents.
- If a violent incident results in a critical injury to a worker, the JHSC representative or worker designate investigates the incident or injury (Section 9(31) OHSA) and reports to the MOL and JHSC.

Emergency Response Measures

Refer to the organization's emergency response procedure (code white, staff alert).

Supports for Employees Affected by Workplace Violence

Management will respond promptly, assess the situation and ensure that these interventions are followed:

- Facilitation of medical attention
- Debriefing (by skilled professional)
- Referrals to community agencies, treating practitioner and employee assistance program

- Referral to trade union
- Completion of incident reports, WSIB reports, reports to MOL (critical injury or fatality)
- Reporting to police (as required)
- Team debriefing

Risk Assessment

Management (with worker involvement) assesses workplace violence hazards in all jobs, and in the workplace as a whole. Risk assessments are reviewed annually and whenever new jobs are created or job descriptions are substantially changed. A risk assessment tool is appended.

Education

All new employees will receive both general and site-specific orientation to the Workplace Violence Prevention Program. In addition, all employees will receive an annual review of both the general and site-specific components of the program.

Any training developed, established and provided shall be done in consultation with and in consideration of the recommendations of the joint health and safety committee.

Program Evaluation

The effectiveness of the Workplace Violence Prevention Program is evaluated annually by management and reviewed by the joint health and safety committee.

Workers, managers and supervisors are accountable for the policy and procedures related to workplace violence. This is part of the responsibilities to comply with health and safety policy in the manager, supervisor and worker's job descriptions. Management responsibilities for enforcing policy and procedures, investigation of and response to workplace violence are also included in health and safety components of job descriptions.

Accountability

All workplace parties are accountable for complying with the policy, program, measures and procedures related to workplace violence.

Records

All records of reports and investigations of workplace violence are kept for five years.

Policy review

This Violence in the Workplace Prevention Policy and Program will be reviewed annually.

Dated at _____ on _____, 200__

Signed _____
(Senior management to sign)

APPENDIX D–18: Workplace Violence Reporting Procedures

Any member of (Name of organization) who believes that he or she is threatened or who experiences or witnesses any workplace violence as defined in the Workplace Violence Prevention policy (insert policy #) must promptly report it using the Employee Workplace Violence Incident Report form. In the event of immediate danger, refer to steps outlined in the Emergency Response Procedure (cross reference organization policy or procedure).

When threatening or violent behaviour is connected to (Name of organization) or carried out on (Name of organization) property, the employee must report incidents immediately using the following procedure:

1. All staff are responsible for reporting threats or violence to their supervisor or manager. If the employee's direct supervisor is involved in the act, the employee contacts the human resources department. In all cases, the Employee Workplace Violence Incident Report form needs to be completed.

2. If the perpetrator has no relationship to the organization (Type I) or has a personal relationship with an employee (Type IV), the supervisor consults with human resources personnel and contacts the police department. The police are also to be called in incidents involving serious, life-threatening injuries to any client or employee.

3. Report incidents of client abuse immediately and complete a client incident report form. The supervisor must immediately notify the appropriate agency.

4. Supervisors must investigate all reports of violence. If cases of staff-to-staff, staff-to-management, or management-to-staff incidents, contact human resources and the union representative.

5. (Name of organization) takes all reported incidents of violence seriously and will not ignore, condone or tolerate disruptive, threatening or violent behaviour by any member of the organization.

6. Managers, supervisors, staff or visitors engaged in such behaviour shall be removed from the premises as quickly as safety permits. They shall be banned from access to (Name of organization's) premises pending the outcome of an investigation. The investigation will be conducted by the selected response team members who will be assembled at the direction of the manager/administrator/director or his/her designate.

7. (Name of organization) will do its best to preserve and protect the anonymity of those involved and confidentiality in the alleged case. However, it may not be possible to preserve confidentiality or anonymity of those involved as it may be necessary for (Name of organization) to take action, including consultation with others.

8. If an individual involved believes the matter has not been resolved in a satisfactory manner, the individual may file a grievance in accordance with the employee grievance policy reference policy number. In no circumstances will any person who in good faith reports an incident of threats, intimidation or violence, or assists in its investigation, be subject to any form of retribution, retaliation or reprisal.

9. Any person who makes or participates in such retribution or retaliation, directly or indirectly, will be subject to disciplinary action. A person who believes s/he has been or is being subjected to retribution or retaliation should immediately notify the director of human resources, his/her designate or the company owner or file a reprisal complaint with the Ontario Labour Relations Board or file a grievance.

Prevention Programs

(Name of organization) provides a confidential employee assistance program (EAP) to assist full-time employees with personal problems. A list of other agencies that can help with problems is in the human resources office.

(Name of organization) also provides training for recognition and prevention of violence through workshops, in-service activities for faculty and staff, and printed materials.

The director of human resources or his/her designee will conduct exit interviews when employees retire, resign or are transferred or terminated, to help identify potential workplace violence-related threats or problems.

Once the captor has left:

a) Call the police if they have not already been called.

b) Administer first aid to victims.

c) Supply information to the police: observations about captor, direction of flight and a description of any weapon or vehicle used.

If you witness a hostage situation:

- Evacuate people from the immediate area and make sure that no one can wander into the area.
- Notify the person in charge and call the police.
- Document any demands made by the hostage taker.
- Provide police assistance as required.
- Ensure that counselling of victims is initiated.

Appendix D–19: Tips for Developing an Emergency Response Plan

Use these steps when developing an emergency response plan:

- Define the types of incidents to which the emergency response team responds. Establish internal emergency numbers or code words to alert the team and employees that urgent help is required.
- Determine the composition of the emergency response team and the number of members that are needed to provide 24-hour coverage. The response team can include front-line staff such as nursing or health care staff, supervisors or managers, staff social workers, security personnel and law enforcement officials.
- Define responsibilities for reporting violent incidents. Identify situations in which employees would need emergency services and ensure that staff know how to access the assistance of the emergency response team.
- Determine how to secure the site.
- Develop procedures for the team to follow in various situations.
- Identify the circumstances that would require a command centre and establish procedures for setting one up.
- Assign responsibilities for decision-making and action to those staff members who have skills and authority.
- Identify the person responsible for contacting external emergency services such as security, the police, victim support services and other outside assistance. Detail the circumstances in which external services should be called.
- Develop procedures to:a) obtain immediate first aid or medical help
  b) deal with emergency staff and police
  c) complete reports
  d) manage sensitive communications (for example, informing the victim's family, other employees or the media)
- Develop an evacuation plan. Identify the conditions that would require an evacuation.
- Identify situations that would make it unsafe to evacuate the building and that would require a lock-down (a secure location where building occupants could take refuge). Identify the lock-down location and a lock-down plan.
- Identify and document procedures to ensure the safety of all staff.
- Design a form that the team can use to report each incident. The report should include: date; time; location; names of team responders; names of employees, clients and others who were present; witnesses; description of incident; team interventions; and debriefing of victims, witnesses and others.
- Train team members to respond to and defuse potentially violent situations, using non-violent crisis-intervention training and management of aggressive behaviour training, for example.
- Hold regular practice drills for the team and the organization.
- Evaluate the emergency response team
- Review the emergency response plan on an annual basis. Update the plan to keep it current and effective.
- Ensure the JHSC is consulted in the development of the Emergency Response Plan and training.

Procedures for response to hostage-taking

If you are taken hostage:

- Remain calm. Listen closely to your captor's instructions. Speak only when spoken to. Do not talk down to the captor or attempt to argue.
- Follow all instructions. Avoid making suggestions or comments.

- Remove any items that could identify you as a potential threat, for example, items identifying you as a member of the military, a police officer or a religious official.
- Avoid staring at your captor.
- Do not move or attempt to reach for anything unless you first ask permission.
- Observe as much as you can; your information may help the authorities.
- Stay clear of windows and doors as you may be in the line of fire. Drop to the floor if shots are fired.
- Do not attempt to stop or chase your captor if he or she leaves.

Appendix E: Summary of Applicable Legislation

Occupational Health and Safety Act

The *Occupational Health and Safety Act* (OHSA) does not specifically mention workplace violence. The provisions mentioned below have been used by the Ontario Ministry of Labour to deal with violence as a health and safety hazard.

Duties of Employers

- Section 25(2)(a): Provide information, instruction and supervision to a worker to protect the health or safety of the worker
- Section 25(2)(h): Take every reasonable precaution in the circumstances for the protection of a worker.
- Section 25(2)(j): Prepare and review at least annually a written occupational health and safety policy, and develop and maintain a program to implement that policy.

Duties of Supervisors

- Section 27(2)(a): Advise a worker of the existence of any potential or actual danger to the health or safety of the worker of which the supervisor is aware.
- Section 27(2)(b): Provide a worker with written instructions as to the measures and procedures to be taken for protection of the worker.
- Section 27(2)(c): Take every precaution reasonable in the circumstances for the protection of a worker.

Duties of Workers

- Section 28(1)(d): Report to his or her supervisor any contravention of this Act or regulations or the existence of any hazard of which he or she knows. This requirement can be interpreted to include any threat of violence or presence of a violent person.

Health Care and Residential Facilities Regulation

- General Duty to Establish Measures and Procedures
- Section 8: Every employer in consultation with the joint health and safety committee or health and safety representative, if any, and upon consideration of the recommendation thereof, shall develop, establish and put into effect measures and procedures for the health and safety of workers.
- Section 9(1): The employer shall reduce the measures and procedures for the health and safety of the workers established under Section 8 to writing and such measures and procedures may deal with, but are not limited to, these:
  - Safe work practices
  - Safe work conditions
  - The proper use, maintenance and operation of equipment
  - The reporting of unsafe or defective devices, equipment or work surfaces
  - The use, wearing and care of personal protective equipment and its limitations.
- Section 9(2): At least once a year, the measures and procedures for the health and safety of the workers shall be reviewed and revised in the light of current knowledge and practice.

- Section 9(3): The review and revision of the measures and procedures shall be done more frequently than annually if:

  (a) he employer, on the advice of the joint health and safety committee or health and safety representative, if any, determines that such a review is necessary; or

  (b) there is a change in circumstances that may affect the health and safety of a worker.

- Section 9(4): The employer, in consultation with and in consideration of the recommendation of the joint health and safety committee or health and safety representative, if any, shall develop, establish and provide training and educational programs in health and safety measures and procedures for workers that are relevant to the workers' work.

The Criminal Code of Canada

Under the Criminal Code of Canada, assault is a criminal offence. Employers and employees have the right to call the police to investigate and lay charges when an employee has been assaulted in the workplace.

- An assault also includes attempts or threats to use force, including gestures that imply a serious threat. If the police lay charges under the Criminal Code, the Crown Attorney prosecutes the case and the victim is called as a trial witness.
- Criminal Code of Canada
  - Section 265 of the Criminal Code defines assault as "the intentional application of force to another person without that person's consent." Section 264(1) states that "No person shall, without lawful authority and knowing that another person is harassed or recklessly as to whether the other person is harassed, engage in conduct referred to in subsection (2) that causes that other person reasonably, in all the circumstances, to fear for their safety or the safety of anyone known to them."
  - Section 264(2): The conduct mentioned in subsection (1) consists of
    (a) repeatedly following from place to place the other person or anyone known to them;
    (b) repeatedly communicating with, either directly or indirectly, the other person or anyone known to them;
    (c) besetting or watching the dwelling-house, or place where the other person, or anyone known to them, resides, works, carries on business or happens to be; or
    (d) engaging in threatening conduct directed at the other person or any member of their family.

The Ontario Human Rights Code

The Ontario Human Rights Code has a "prohibited grounds of discrimination" clause. This clause makes it unlawful for employers to treat workers or job applicants differently for certain "prohibited" reasons. The reasons include race, ancestry, place of origin, colour, ethnic origin, citizenship, religion, sex, sexual orientation, disability, age, marital status, family status and record of offences. It is unlawful for anyone to harass an individual on the basis of these factors. Harassment includes inappropriate comments, jokes or suggestions. Sexual harassment includes unwanted touching.

Under the Code, employers must prevent or stop harassment in the workplace. Workers have the right to file a complaint with the Ontario Human Rights Commission. Employers cannot penalize or threaten to penalize a worker who has filed a complaint.

- Preamble: It is public policy in Ontario to recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination that is contrary to law, and having as its aim the creation of a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province.
- Section 5(1): Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability.

- Section 5(2): Every person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, age, record of offences, marital status, family status or disability
- Section 6: Every person has a right to equal treatment with respect to membership in any trade union, trade or occupational association or self-governing profession without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap.

The Workplace Safety and Insurance Act, 1997

The Workplace Safety and Insurance Board of Ontario (WSIB) regards an injury resulting from an act of violence as it would any other workplace injury. Injured workers who require medical attention or who have lost work time because of a violent incident in the workplace have the right to claim WSIB benefits. The worker can choose either to accept WSIB benefits or to sue the assailant privately for damages.

- Workers who suffer from stress after a violent incident may also be entitled to WSIB benefits. Section 13(5) of the Workplace Safety and Insurance Act provides that workers are entitled to benefits for mental stress as a result of an acute reaction to a sudden and unexpected traumatic event. There is no benefit entitlement for mental stress that arises gradually over time owing to workplace conditions in general.
- Section 13(5) states, "A worker is entitled to benefits for mental stress that is an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment. However, the worker is not entitled to benefits for mental stress caused by his or her employer's decisions or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment."
- A benefit entitlement also exists for mental stress that is a delayed acute reaction to a sudden and unexpected traumatic event. Onset of this type of stress can be delayed by days, weeks or months; the delay does not mean that the reaction arose gradually over time.
- Examples of sudden and unexpected traumatic events are armed robberies, hostage-takings or witnessing an act of extreme violence. Other examples are immediate death threats, physical violence or the immediate threat of physical violence, or immediate and intense sexual or racial harassment. In these instances, the perpetrator must be present and able to carry out the threat or act upon the harassment.

The Compensation for Victims of Crime Act

A person who is injured as a result of a crime can claim compensation under the *Compensation for Victims of Crime Act* if he or she has requested that charges be laid against the perpetrator. If the claim is accepted, the victim has the right to a hearing by the Ontario Criminal Injuries Compensation Board, which determines if the applicant qualifies. The victim must have a medical examination at the time of the injury and at the point of recovery, and must also submit a police report of the incident to the Board. A victim has up to one year from the date of the crime to file an application with the Board.

Regulated Health Professions Act

Under the *Regulated Health Professions Act*, sexual abuse of patients by a health care professional must be reported, and regulated health professionals must receive education on abuse prevention. The Act establishes the concept of "zero tolerance" for the abuse of patients. By extension, it advocates abuse-free workplaces and fosters the philosophy that violence is unacceptable and that perpetrators must be held accountable for their actions. Neither abuse of health professionals nor abuse by health professionals can be dealt with in isolation, if the overall goal is workplace violence prevention.

Notes:

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