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Implementing violence prevention legislation in hospitals: Final report

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Executive Summary

Violence and aggression in healthcare settings are significant occupational health concerns. Workplace violence prevention legislation (Bill 168) came into effect in Ontario in 2010. The bill's amendments to the *Occupational Health and Safety Act* direct employers to: establish violence prevention policies that are reviewed annually; develop and maintain a program for controlling risks, summoning assistance, and reporting and responding to incidents; assess risks of workplace violence; and train and educate employees.

This study, involving five hospitals selected to represent the diversity of acute care hospitals in Ontario, examined:

- the measures organizations have taken to meet the requirements of Bill 168 and perceptions of how these measures have played out in practice;
- contextual factors (internal and external to the workplace) that have supported or challenged implementation of violence prevention policies and practices; and
- stakeholder perspectives about ongoing challenges associated with the prevention of workplace violence in this sector and strategies for improvement.

The study involved interviews with external key informants (policy-makers, training developers, union and employer representatives; N=8) and hospital management (executive leaders, clinical directors, supervisors; N=40), as well as 18 focus groups with frontline clinical staff (nurses, allied health workers, social workers; N=64) and non-clinical staff (food service, security and laboratory workers; N=44). Additionally, some frontline clinical staff were interviewed (N=9) who were either unable to attend the focus groups or preferred to speak to us one-on-one. Field work was conducted between May 2016 and May 2017, prior to the release of the progress report of the Workplace Violence Prevention in Healthcare Leadership Table.

KEY FINDINGS

Participants across sites agreed that a "cultural shift" has resulted in decreased acceptability of violence in healthcare. Key incidents like the Lori Dupont murder,

legislative changes, workplace inspections and lobbying by groups like the Ontario Nurses' Association (ONA) have helped keep healthcare-related violence in the spotlight.

Research participants described the implementation of violence prevention programs and some of the challenges that still exist.

Training

All hospitals provided training on de-escalation, summoning assistance and reporting, with a core curriculum being mandatory for all staff and more intensive training often being delivered to those working in "high risk" areas. However, a high overall training workload resulted in difficulties managing coverage and, in some instances, the expectation that staff would complete training on their own time. Hospitals relied heavily on online training, which some staff felt did not adequately prepare them for real-life scenarios and made information retention difficult.

Organizational risk assessment

Organizational risk assessments examining work practices and environmental factors were conducted at each hospital. A violence risk assessment toolkit developed by the Public Services Health and Safety Association was cited as a valuable resource. Some confusion existed among staff about how often risk assessments were carried out and their purpose, particularly because outcomes were not always known to staff. A lack of consistency in the process (tools used, frequency and quality) contributed to this confusion. With the exception of one site, risk assessments tended to be reactive (in response to an incident or order) rather than proactive.

Flagging

Patient flagging was one of the most contentious issues discussed. Workers wanted information about previous aggressive behaviour, but some felt flagging stigmatized patients and could lead to differential treatment. A degree of "permanency" in the flagging process and a lack of gradation were raised as issues. Workers reported some hesitation flagging patients when the violent act was perceived as unintentional or lacking malice. Information was not always well-communicated, particularly to non-clinical staff, and sometimes flagging did not result in clear clinical or

behavioural plans. Participants had concerns over a lack of procedures for flagging family members and outpatients.

Summoning assistance

Hospitals had different ways of summoning assistance, including the use of duress badges, screamers, intercoms, telephones and verbal communication. Most participants appreciated having access to personal alarms, and this tangible investment by the hospital was viewed as a sign of commitment to violence prevention. However, when alarms frequently malfunctioned, they were not trusted or used. Some workers reported experiencing confusion about what to do when everyone assembled in response to an activated alarm (e.g. during code white situations).

Security

Differences were reported between hospitals that had in-house security teams and those that worked with externally contracted security teams. In-house security teams were viewed more favourably by staff, and were seen as being well-trained and knowledgeable about the hospital's policies and environment. Staff raised concerns about contracted-out security teams, which were described as being poorly trained and inexperienced. Security was described as a feature of violence prevention programs that was most often negatively affected by budget cuts. Some confusion and conflict existed about the role of security on certain units (e.g. mental health units).

Reporting

At each site, management spoke about the importance of fostering a culture of reporting. Reported incident rates were viewed as an important driver of policy, programming and training. All sites had or were moving toward electronic reporting. Certain incidents were less likely to be reported – verbal aggression, bullying, violent acts without perceived intent, and incidents that resulted in no injury. Barriers to reporting included complicated and long reporting systems, little time to report during work hours, a lack of follow up after a report was made, and fear of reprisal.

Concluding observations

Hospitals are large, complex organizations, and the needs of staff in different departments should be examined when it comes to violence prevention programming. Input from frontline staff into the development of programs and policies, as well as regular check-ins, would ensure that polices are having the intended “on the ground” consequences. Follow-up and transparency around risk assessment outcomes, incident reporting and flagging would give workers concrete information about efforts to improve safety. Tangible investments in the form of personal alarms or security personnel send a powerful message to staff about how seriously violence prevention is viewed by hospital leadership. Hospitals and legislative bodies should consider how violence prevention can become a “forever issue.” Likely, this will require sustained commitment of human and financial resources. Finally, regular information-sharing opportunities would be valuable, providing opportunities for hospitals to discuss best practices and learn from incidents and near misses.

Introduction

Violence and aggression toward healthcare workers has been recognized as a significant health and safety concern. It has been described as one of the most complex and dangerous occupational hazards facing nursing today (McPhaul et al., 2004). In 2004, the Canadian General Social Survey on victimization estimated that there were 356,000 self-reported incidents of workplace violence across Canada (Léséleuc, 2007). In Ontario, workplace violence continues to be one of the top five most serious hazards and contributors to lost-time injuries in the healthcare sector (Ontario Ministry of Labour, 2014).

The Ministry of Labour (MOL) identifies workplace violence as an important priority in the enforcement plans for the Ontario healthcare sector (MOL, 2017). In February and March 2013, the Ontario MOL conducted a blitz on workplace requirements to protect workers from violence. Inspectors conducted 285 visits to 221 workplaces in the healthcare sector and issued 307 orders under the *Occupational Health and Safety Act* (OHSA), including one stop-work order (MOL, 2013). This blitz provided a snapshot of how organizations have responded to workplace violence requirements and demonstrated a number of inadequacies with respect to policy implementation. A Violence Prevention Summit organized by the Ontario Hospital Association (October 1, 2015) brought together stakeholders from the acute healthcare sector across the province. There was a strong recognition among participants that the healthcare sector continues to struggle with the implementation of policies and practices that will lead to sustained change in the incidence of violence in the sector.

While accreditation reports and inspection blitzes can tell us about levels of compliance, no information is available that examines how policies and procedures function in practice or that describes the nature of implementation challenges. Therefore, the goal of this study was to examine the underlying mechanisms and contextual influences that support or limit the successful implementation of policies and processes for the prevention of workplace violence in Ontario's healthcare sector.

Background: Bills 168 and 132

Bill 168 is an amendment to the OHSA that came into force on June 15, 2010 to help protect workers from workplace violence and harassment. The bill requires

employers to establish violence prevention policies that are reviewed annually; to develop and maintain a program for controlling risks, summoning assistance, reporting and responding to incidents; to assess risks of workplace violence; and to train and educate employees (OHSA, 2010).

OHSA Subsection 1(1) defines “workplace harassment” as “engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome.” It also defines “workplace violence” as:

a) the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
b) an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,
c) a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Prior to the data collection phase of this study, Bill 132, which is new legislation on sexual violence and harassment, was introduced. The research team thought it appropriate to include this topic briefly in the interviews and focus groups. Bill 132 came into full effect on September 8, 2016 and its amendment to the OHSA expands the meaning of workplace harassment and imposes new employer responsibilities around reporting procedures and the investigation of workplace harassment. For further information about both bills please refer to the Ontario MOL website (www.labour.gov.on.ca).

Methods

Overview

A case study was conducted with five acute care hospitals, and an exploratory qualitative research approach was taken to:

(i) examine the measures organizations have taken to meet the requirements of workplace violence legislation and perceptions of how these procedures have worked in practice;
(ii) understand how decisions are made about implementation strategies and processes used to prevent violence;
(iii) identify contextual factors (internal and external to the workplace) that have supported or challenged implementation of violence prevention policies and practices; and
(iv) gain stakeholder input (e.g. from organizational informants, frontline workers, regulators, policy-makers) about ongoing challenges associated with the prevention of workplace violence in this sector and strategies for improvement.

The study consisted of four parts:

(i) interviews with external key informants;
(ii) a document review of materials provided by each hospital (e.g. policies, procedures, resources, guides) related to their workplace violence prevention program;
(iii) interviews with organizational leaders (e.g. senior management, supervisors) responsible for leading and overseeing workplace violence prevention initiatives; and
(iv) focus groups and/or interviews with frontline staff and joint health and safety committee (JHSC) members.

Concepts from the implementation science literature were used to study the implementation experience of workplace violence legislation. This included the initial exploration and adaptation of programs and policies; program installation; initial implementation; full operation; innovation; and sustainability of policies and practices (Fixsen et al., 2005). In addition, the research team applied a three-level implementation framework introduced by Fixsen and colleagues to support an in-

depth review of organizational investment in workplace violence policies and programs. These different levels of implementation were used as a lens to 1) describe written evidence of policies and procedures on workplace violence (paper implementation), 2) examine the presence of activities that align with these procedures (process implementation), and 3) examine whether the activities are perceived as helping to reduce risks in the workplace (performance implementation).

The University of Toronto Research Ethics Board reviewed and approved the study protocol. The study protocol was also reviewed and approved by individual research ethics boards at four of the five hospitals.

Recruitment and sampling

The sample included frontline healthcare staff, non-frontline healthcare staff, and management representatives from five acute care hospitals in Ontario. Eleven hospitals were initially short-listed, from which eight were contacted. Five sites confirmed their participation. These five sites were recruited through the members of the project advisory committee, Institute for Work & Health (IWH) staff and the Public Services Health and Safety Association, as well as via cold-calling. Once initial contact was established with a hospital, several meetings were conducted between the research team and hospital key contacts to discuss the study and finalize the data collection plan. The hospitals also signed an organizational consent form once their participation was confirmed. It is important to note that the research team relied on the key contact at each site to recruit participants for the focus groups and the interviews; therefore, the data collection was shaped by the structure of the hospital and who we were permitted to speak with.

Participants

The five sites were all acute care hospitals based in Ontario. There was a mix of urban, suburban and rural hospitals from Southwestern Ontario, Eastern Ontario and the Greater Toronto Area. The hospitals varied in size (ranging from 40 to 1,000 beds), and there was a mix of single- and multi-site hospitals.

Table 1: Site Description

Description	Number of sites in the sample
Location	2 Greater Toronto Area 2 Southwestern Ontario 1 Eastern Ontario
Size	2 large (500+ beds) 2 medium (100-500 beds) 1 small (less than 100 beds)
Single-site vs. multi-site	2 multi-site 3 single-site

The number of participants across the five hospitals totalled 157. This included participants from 18 focus groups as well as 49 one-to-one interviews (see Table 2).

The research team categorized participants from the five sites as follows (Table 3):

1) frontline health/medical staff providing medical care to patients (e.g. nursing staff, allied health staff, diagnostic services staff, social workers, rehabilitation assistants)
2) frontline non-medical staff providing non-medical care or services to patients (e.g. staff from laboratory, food services, environmental services, security, infection control)
3) management representatives who were not directly involved in providing patient care or other frontline services (e.g., clinical directors, unit managers, executive leadership, and managers of human resources, occupational health and safety and patient relations)

There was a balance of units represented, including emergency and psychiatric units, several in-patient units (e.g. NICU, cancer care) and some outpatient clinics (e.g. renal, mental health). At one of the sites, a focus group consisted exclusively of staff from the emergency department. Focus groups conducted at the multi-sited hospitals were all JHSC members. Other committees involved in workplace violence prevention, like code white committee members, were also represented in the focus groups.

Table 2: Interview and focus group (FG) breakdown per site

Site	# focus groups (# participants)	# interviews	Total # participants per site
1	3 FGs (5+4+7)	8 non-frontline 9 frontline	16 focus group 17 interview
2	4 FGs (9+11+13)	7 non-frontline	33 focus group 7 interview
3	3 FGs (4+8+8)	8 non-frontline	20 focus group 8 interview
4	3 FGs (7+6+7)	6 non-frontline	20 focus group 6 interview
5	5 FGs (8+7+4)	11 non-frontline	19 focus group 11 interview
	Total FGs: 18 Total FG participants: 108	Total interviews: 49	Total participants: 157

Table 3: Participant breakdown per site

Site	Frontline health/ medical staff	Frontline non-medical staff	Management representatives*
1	19	6	8
2	19	11	10
3	12	7	9
4	6	13	7
5	8	7	15

*Note that some participants had dual roles. If they had management responsibilities, they are counted here as management representatives.

Procedure

External key informants

Eight external key informants were interviewed from May to August 2016, prior to data collection at the hospitals. They included senior policy makers and senior leaders from health and safety associations, unions and training organizations. They all had experience related to occupational health and safety, specifically workplace violence prevention within the healthcare sector, which helped provide important contextual information for the study. Interview questions encompassed: the role their organization had played in violence prevention activities in Ontario, responses to Bills 168 and 132, limitations or strengths of the legislation, pressing issues to be addressed including implementation challenges, and programs or policies that have been effective in workplace violence prevention. External key informants suggested possible sites to include as case studies and described important characteristics to consider in the selection of the sites. For example, there was agreement that the study should include a site that was small and in a rural environment.

Documentation review

Prior to data collection at a hospital, information about the violence prevention program at that site was reviewed. This review of materials and documents allowed the research team to gain preliminary knowledge about the various programs and policies put in place by each hospital to prevent and manage workplace violence. Hospitals forwarded these documents via email. The documents included, but were not limited to: codes of conduct; codes on respectful workplace behaviour; policies and procedures on incident reporting, risk assessment, panic alarms, and flagging alerts; training materials including new worker orientation; and safety protocols for community workers. Access to these resources allowed the research team to customize the interview and focus group questions and insert additional probes as needed.

On-site interviews and focus groups

Semi-structured interview and focus group guides were developed collaboratively by the research team and study co-investigators before beginning data collection at the hospitals. The one-to-one interview questions, designed for participants who were in a management or non-frontline role and who were interviewed individually, covered

the various components of the workplace violence and harassment program (e.g. risk assessment, training, flagging, code whites) as well as important contextual factors and components of program evaluation. Focus group questions were also semi-structured in nature and designed for frontline participants to comment on how the violence prevention program was “working on the ground.” Participants were asked about the implementation of the different workplace violence policies, including barriers and facilitators, as well as internal and external contextual factors that could impact the rates of workplace violence. The interview guides prompted participants to consider the different types of workplace violence within healthcare settings.

Interviews and focus groups were conducted at the hospital sites between October 2016 and May 2017 by experienced qualitative interviewers and focus group facilitators from the research team. Study information letters and consent forms were distributed to the participants prior to and during the focus groups/interviews. Written consent to record each focus group/interview was obtained from all participants prior to the start of the focus group/interview. All participants were offered refreshments and an honorarium in the form of a $25 gift card. Some participants declined the honorarium.

One-to-one interviews were held in person or via telephone, depending on the participant’s location, work schedule and preference. Focus groups were all held in-person, and focus group participants were given the option to do one-to-one interviews if they were unable or unwilling to participate in a focus group. Interviews lasted between 30 and 60 minutes, and focus groups lasted between 60 and 90 minutes. All interviews and focus groups were audio-recorded and transcribed verbatim. The interview/focus group structure allowed for follow-up questions, probes and new avenues of inquiry.

Data analysis

The research team used a thematic approach to the data analysis, which involves organizing content systematically and identifying, analyzing and reporting themes. Transcripts were entered into a qualitative data analysis software program (NVivo, QSR International Pty Ltd. Version 10, 2012) for data storage and coding. In the first phase of coding, three researchers read a sample of interview transcripts and established a preliminary list of codes. The research team reviewed the content

assigned to these codes, and then developed a coding manual containing a definition for each code and an explanation for how its content would apply to the research objectives.

Transcripts were then coded in two rounds by two researchers. Once the first round of coding was complete, the coded text was sent to the second reviewer to add additional codes or to identify sections that may have been miscoded. Common themes and concepts across codes that captured key insights were identified. Any discrepancies in coding and interpretative differences were discussed and resolved by the research team.

Data pertaining to each of the codes were then reviewed. Prevalence of a theme was considered, as well as whether the theme captured key insights in relation to the research question. Key findings regarding the violence prevention program components were then compared across sites. Analysis and interpretation examined core experiences, underlying assumptions, shared and divergent perspectives, contradictions, silences and gaps (Poland & Pederson, 1998) in the data, and highlighted the differences in responses between frontline and non-frontline staff, and between management and staff.

Methodological considerations

There are several methodological issues to consider when reading the research findings. First, this study was not intended to be an evaluation of each site's or hospital's violence prevention program and was not designed to provide such findings. We avoid comparing the sites directly, in part because we do not want to identify any of the sites. We were also reliant on the nature and amount of information that was provided to us. There were some gaps in the documentation review process because some of the hospitals could only provide partial information due to privacy/confidentiality issues, technical and data access issues and time constraints.

Second, a hospital's participation in the study was a voluntary decision of its management and it is likely that participating hospitals are more interested and invested in violence prevention than those that chose not to participate. Therefore the findings of this study may not be representative of the full spectrum of workplace violence programs in Ontario hospitals. In addition, data collection was shaped by the organizational structure of the hospital and to whom we were permitted to speak.

For example, we were not given permission to speak with any non-JHSC frontline workers at one of the sites, which reduced the variety of perspectives in the data from that site. It also led to situations of management and frontline workers attending the same focus groups, where some individuals may have been reluctant to share their perspectives (rectified later in the study by separating the management and worker members into different focus groups). As a result of these conditions, we may not have heard from all staff who were interested in participating in the study.

Findings

Impetus for policy development and implementation

Senior management at each site described violence prevention as a priority for their hospital. While each hospital had violence prevention policies and programs in place prior to the introduction of Bill 168 in 2010, the legislation was described as an important impetus for the development and implementation of programming in this area: it formalized the need for violence prevention programming and was a "beacon" that helped guide hospitals in their violence prevention activities. However, other factors also provided significant impetus for the development of policy and programming. In particular, the 2005 murder of Lori Dupont, a nurse in Windsor, Ontario, was considered a turning point in how violence in hospitals was viewed.

> *"[Lori Dupont] was a member of the Ontario Nurses' Association. ONA is very passionate about this topic, and rightly so. So, at the time, yes, I would say that there was a heightened awareness and maybe a push, for a lack of a better way of describing it, to making sure that all hospitals comply with the legislation as soon as they could." [Patrick, External Key Informant]*

The tragic event led to negative media attention related to gaps in workplace health and safety laws, and pointed to shortcomings in the ways that hospitals responded to workplace harassment and violence. The subsequent anti-violence public campaigns mounted by organizations like ONA were also cited as helping bring considerable attention to violence in the healthcare sector. More recent events such as the appointment of the "Workplace Violence Prevention in Health Care Leadership Table," violence-related inspection blitzes and the issuing of orders by the MOL were also viewed as keeping pressure on healthcare organizations to continue to improve their activities in the area of violence prevention. Participants noted that some hospitals have also put management structures into place that make senior leadership accountable to their boards of directors for the development and implementation of violence prevention programs.

Research participants discussed their violence prevention policies and programs and how these were working "on the ground." Below, we examine the key components of workplace violence prevention programs, factors that facilitated their implementation

and challenges that were encountered. We also examine how program design and implementation can impact violence prevention in hospitals.

Violence prevention programs—overview of key policies and initiatives

Training

Training was an important part of each hospital's violence prevention program. A number of participants noted that most nurses (and other healthcare providers) did not receive violence prevention training during their clinical education, so hospital-based training was the only training they received in this area. All hospitals had some training on de-escalation, summoning assistance and reporting, with a core curriculum being mandatory for all staff and more intensive training often being delivered to those working in "high risk" areas (e.g. the emergency department) or with "high risk" patients (e.g. dementia patients). A high overall training workload for staff resulted in difficulties managing unit coverage and, in some instances, the expectation that staff would complete training on their own time. Participants also reported inconsistencies related to subsequent ("refresher") training. Refresher training was particularly important for staff who did not encounter violent behaviour regularly and could forget how to use their alarm or how to file a report in the event of an incident. Some workers reported that they received training on reporting when they started and then never again, despite reporting systems and processes changing during that time.

Hospitals relied heavily on online training. In one hospital, for example, virtually all training related to violence prevention and management was completed online. While this afforded flexibility—staff could do the training at different times—some participants felt it made information retention difficult and did not adequately prepare staff for real-life scenarios, which required mock drills, practice scenarios (e.g. proper way to use patient restraints) and training on critical thinking and assessment skills. Online training did not provide staff with the opportunity to discuss issues related to violence with their co-workers and supervisors or ask questions about how to deal with situations they might encounter. Staff also felt it was difficult to retain information from online training.

> *"It would be more helpful if people get the whole training hands-on rather than…sometimes when people answer those questions on a*

computer, sometimes they might not even know the answer and they would just ask their colleague, how do I answer this question? And they would just click it, so they don't get the chance to practice it physically and do it in real time." [Yuri, Site 3 Union Representative]

When reviewing training content provided by hospitals and when training programs were described in focus groups, we noted less focus on horizontal (i.e. between peers) violence and harassment than on other types of violence. Participants in focus groups reported receiving little training in this area of violence, despite horizontal violence and harassment being raised as a concern.

Participants who worked as volunteers in hospitals reported receiving little training in general, despite regularly coming into direct contact with patients and family members.

Organizational risk assessment

Organizational risk assessments examining work practices and environmental factors were conducted at each hospital. External key informants noted that the legislation was vague about the specifics of risk assessments; for example, how often they should be done, in what circumstances and what factors they should examine.

"I do know that there are some hospitals who did the risk assessment to comply with the legislation in 2010 and, as of last year, had not redone the risk assessment. And the risk assessment says you have to do it as often as necessary to protect workers…that's probably another big gap, is what does that actually mean, as often as necessary to protect workers? If you are a hospital and you are having ten incidents every year, maybe that's not a big thing, depending on how big your organization is. But, if you're having ten one year and twelve the next year and 15 the next year, you're not doing something right here and you should be going back and doing your risk assessment. […] So, as I said before, you do a risk assessment. Okay, good, you have measures and procedures? Yes, I got those and I'm done. And so,

because there are those things in the legislation, that you can just do tick, tick, tick, I don't think anybody is looking at it from a true outcome perspective. So, if we do all of these things, are we actually seeing a reduction and are our workers reporting that they feel more safe?" [Heidi, External Key Informant]

In this study, the reported frequency and formality of risk assessment processes varied by site. A violence risk assessment toolkit developed by the Public Services Health and Safety Association was cited as a valuable resource that provided hospitals with concrete guidance on this legislative requirement. This toolkit was sometimes adapted after initial use to examine particular areas or practices that were hospital specific.

Some confusion existed among staff about the purpose and frequency of risk assessments, particularly because their outcomes were not always known to staff. Some staff, for example, when asked about risk assessments, were not sure if there were differences between organizational or patient-specific risk assessments, inspections conducted by the MOL and assessments conducted for insurance purposes. A lack of consistency in the process (tools used, frequency and quality) contributed to this confusion. One site, for example, seemed to be using four different risk assessment tools across hospital departments. With the exception of one site, risk assessments tended to be reactive (in response to an incident or an order) rather than proactive. Some participants were critical of the risk assessment process in their hospital. They felt that risks assessments tended to be administrative exercises rather than tools that led to concrete risk mitigation strategies.

"So risk assessments are just, I think, sometimes for optics, not for any other reason. I've seen some risk assessments done using the impact severity. I've seen others where I can't actually figure out how they've come up with low risk assessment. It's really very arbitrary even though we're supposed to be using a framework. I think it's just whatever is convenient that day or whatever we need to make it look like." [Jenna, Site 2 Nurse Educator]

There was also a concern that, because the risk assessment process was time consuming, it would not be done very often. Some questioned the long-term sustainability of the risk assessment approaches being used.

Flagging

Flagging is the process of identifying individuals who have demonstrated aggressive or violent behaviour or have a history of violence, in order to alert and protect staff. Various policies and practices were used to alert staff to the potential of violence, ranging from verbal communication and signage to wrist bands, charting and electronic flagging. One of the five sites had a very informal process consisting of staff verbally conveying information as needed. This process was vague and unknown to most study participants (staff and management) in that hospital.

Patient flagging was a contentious issue. Some participants believed there was a conflict between MOL legislation directing employers to inform workers of and protect them from hazards (which in some cases could be individuals with a history of violence) and privacy legislation that directed hospitals to protect the privacy of patients. This perceived legislative conflict sometimes left workers and managers uncertain about what kind of information could be shared and with whom.

Furthermore, although workers wanted information about previous aggressive behaviour, some felt that flagging stigmatized patients and could lead to differential treatment. A concrete example given was that some individuals flagged in a hospital setting had difficulty getting into community-based care because some community-based organizations refused to treat patients who had a history of violence.

> *"What does concern me, honestly, in terms of patient rights and stigma…It's hard to find placement for people if you put those labels on them in such a formalised way as well. In certain populations, once you put that behavioural risk on them and you know…Particularly with the senior's dementia population." [Focus group participant, Site 5]*

This was not only worrisome for workers managing patients with dementia, but also patients with psychosis, age-related cognitive decline or even temporary disorientation that contributed to a violent incident. In these circumstances it was felt that patients would be stigmatized over behaviour they could not control.

> *"So, if the patient came off of the anaesthetic and was temporarily violent until they became aware of their surroundings, you wouldn't*

want to flag that person, because that stays on their file for quite some time." [Russell, Site 1 Safety Consultant]

A degree of "permanency" in the flagging process and a lack of gradation were also raised as issues. For example, at some sites, the same flags would be applied to a patient who had been verbally aggressive and to a patient who had assaulted and injured staff. Workers questioned the fairness of this approach. In addition, there was a concern that such an approach would overestimate the risk to staff in some instances and underestimate it at other times. In many focus groups there were also discussions about the permanency of a patient flag. In most instances a flag remained on the patient record, even if the person had visited the hospital numerous times without incident or the aggressive behaviour had been situation specific. Typically, hospitals had mechanisms in place that allowed a patient to appeal a flag in their chart; however, the process to get the flag removed was described as long and difficult by participants.

"If patients are identified as violent or with a history of violence, they're flagged permanently. You could have somebody who is upset about the loss of a child and swears, and somebody who lashes out with a weapon and hurts somebody, or kills somebody even, and they're flagged in the same way. There's no gradation. That's the biggest problem, I think. What ends up happening is it doesn't work for staff, so they sort of pick and choose how to apply it." [Jade, Site 2 Director]

Some participants, particularly those who worked with psychiatric patients, noted that many, if not most, of their patients had at some point exhibited aggressive or violent behaviour. If these patients were all flagged, the flag would become virtually meaningless and staff would ignore it. Staff who worked in emergency departments also worried that flagging patients for incidents such as swearing or yelling would greatly increase their workload and not necessarily make their work environment any safer.

At some sites staff also felt that a flag, when put in a patient's chart, did not always result in any clear clinical or behavioural directives. The flag was simply an alert to staff that a patient may be violent, but did not result in any practical tools that would protect staff from violence.

> *"It's fine to place a flag alert on a patient, but all of you don't have the information as to why that happened, it's supposed to be a symbol of caution, then look into it further. It's not just this patient has had violent behaviour, you know, dot my i's, cross my t's, good to go. You need to take that one step further and make sure that works and everyone is on the same page." [Annalise, Site 1 Safety Consultant]*

In most instances, flagging information was put in a patient's chart. At some sites flagged patients also had special wrist bands and a special sign was put on their door. However, not everyone had easy access to information about a flag, including what incident led to the person being flagged or any specific precautions that should be taken when they were in contact with that patient. For example, at some sites, certain staff that came into contact with patients, like housekeeping, porters or dietary staff, did not have regular access to computers in the course of their jobs and so could not access any digital information about the patient. These workers were asked to liaise with the head nurse to get information about the patient. However, participants noted that often this was difficult because the nurse might be seeing patients or might be otherwise unavailable. Even when a flagged patient had a sign outside his or her door, it would be unlikely that dietary staff or housekeeping would check with the head nurses each time they entered the room about behavioural changes or escalation of behaviour. This could mean that they would not be aware when there was a potential change in risk.

Finally, workers and managers noted that sometimes violence was perpetrated by family members and visitors, not the patient. In these instances, flagging procedures were less clear (or absent all together). Participants were not sure how they would be alerted if a visitor who had been violent in the past returned to the hospital or if flagging could be applied to family members.

Summoning assistance

Staff had different ways of summoning assistance, including the use of duress badges, screamers, intercoms, telephones and verbal communication. Code white teams for managing violent or combative patients, where present, seemed to function well. They were described as being well-trained and reliable. Most participants also appreciated having access to personal alarms. These were viewed

as tangible investments by the hospital that signified commitment to violence prevention.

Some sites, however, had experienced difficulties with alarm technology. There were periods where alarms did not work properly (they were too sensitive or did not work when needed) or areas of the hospital where alarms could not be used to summon assistance (e.g. parking lots, outpatient clinics).

At one site, workers had devices which were not only used to summon assistance in emergencies, but also for general communication. One benefit of this was that due to regular use, it was immediately apparent if the device was not working.

> *"It's part of the [communication] system, how to get porters, get cleaners. It's operational. Which means, you wear it, it's always working. If it's not working, you know within a minute of the start of your shift. It's not like a panic alarm that's on your belt that you maybe use once a month and when you do press it, the battery is dead, it doesn't work, it's broken and we never knew. We went for an operational system. It's expensive. It's cost the organization a lot of money. But it's brought a lot of value." [Colin, Site 3 Manager]*

At other sites, alarms were only used in emergencies. Consequently, their use was less frequent and sometimes it only became apparent that they were not working during an emergency. When alarms frequently malfunctioned, they were not trusted or used. At hospitals with multiple buildings and sites, alarms did not always work uniformly across sites. For example, older buildings did not always have the necessary technological infrastructure to permit use. At some sites there were workers who did not get alarms due to funding constraints or a perception that their role did not necessitate having one.

In general, workers were satisfied with the way that assistance could be summoned. However some workers reported experiencing confusion about what to do once everyone assembled in response to an activated alarm (e.g. during code white situations). Sometimes workers did not know who should take charge of the situation and the role of each individual, particularly if the situation involved staff from other units or security.

> *"I would say, and I don't know if you feel the same way [speaking to another participant], on the [#] floor is where the [unit] is, so we're very close. But if that button gets pushed, I'm one of the first staff to get there, what do I do? I have no idea." [Focus group participant, Site 2]*

Security

A range of security approaches were used in the hospitals studied. At four of the five sites, security personnel were employed. Two of these four sites contracted out their security services while the other two had in-house security. The small community hospital did not use security personnel; maintenance staff functioned in the security role or police were called when needed. The role and structure of security programs was one of the most contentious issues raised. External key informants reported that a lack of consistent security standards in the province led to differences in the structure and role of security services. Security was described as the feature of violence prevention programs that was most often negatively affected by budget cuts (described by one participant as "always on the chopping block"). At some of the sites, staff felt that there were not enough security personnel and that certain units or sites did not have adequate coverage.

Differences were reported between hospitals that had in-house security and those that worked with externally contracted security teams. In-house security teams were viewed more favourably by staff, and were seen as being well-trained and knowledgeable about hospital policies and environments. These security workers tended to be well-paid and the hospital could invest in specialized violence prevention or de-escalation training because turnover was low. Staff raised concerns about contracted-out security teams, which were described as being poorly trained and inexperienced.

> *"Well, then we have 18, 19, 20 year olds who are paid just above minimum wage, who, first of all, it's disgusting because how can I ask someone...I'm paid very good money as an RN. How can I ask someone who's got their whole life ahead of them, for $14, $15 an hour, to step in line, without the experience, without the knowledge of the patient that I do, put them at risk? They get punched in the head, they probably don't have sick time…You can't keep people*

when you're paying them $16 an hour. No one's going to stay for that. You have one bad shift, you're going to quit." [Focus group participant, Site 5]

Staff reported frequent turnover in contracted security which resulted in a lack of knowledge about the hospital. Some staff felt there was a degree of role uncertainty between hospital staff and security when it came to who should take the lead or intervene when a code white was called. This uncertainty was exacerbated by uneven security coverage across sites and units in some hospitals.

Some conflicting ideas existed about the role of security on certain units (e.g. mental health units). Workers from these units stressed that security had to approach patients in ways that did not escalate situations and had to know when it was appropriate to "lay hands" on patients. Such approaches required experience and training. A small number of participants also worried that the engagement of security to keep hospitals safe would result in hospitals becoming "like jails" and this was counter-therapeutic.

Reporting

At each site, management spoke about the importance of fostering a culture of reporting. Reported incident rates were viewed as an important driver of policy, programming and training. This meant that hospital areas where reported incidents were high became areas of focus (for staff training, for example). Similarly, when reported violence rates were low this was perceived by management as a reflection of low incidence. All sites had or were moving toward electronic reporting. As with flagging, this created certain difficulties for staff who did not have easy access to computers.

Certain incidents were less likely to be reported—verbal aggression, bullying, violent acts without perceived intent, and incidents that resulted in no injury. Some staff felt that if they reported each time someone was verbally aggressive, half of their work time would be spent on filling out forms. As with flagging, there was resistance (among some staff) to reporting incidents that were perceived as being outside of the patient's control. A patient coming out of anesthesia and striking a healthcare worker, a child having a tantrum or an elderly patient physically resisting care, were often provided as examples.

We identified a number of barriers to “reporting” in the study. At some sites, reporting procedures were long and described as complicated by workers. When workers did not have regular experience with reporting, the process was perceived as daunting with the forms being inflexible and not accessible. Workers also noted a lack of time for reporting during work hours, with some supervisors expecting them to do this sort of work on their own time.

> *“People have too high of a workload, there are not enough people there. They’re harried and flustered through their whole day, so workers are just kind of like hamsters on the treadmill, and they don’t have enough time in their day to even think about reporting an incident…” [Tamara, External Key informant]*

One of the issues that came up regularly in focus groups was the lack of follow-up and transparency after a report was filed. While managers often discussed clear processes for debriefing with workers and following up, some workers felt that in practice, follow-up was not done consistently or comprehensively. Further, many workers also said that reporting rarely resulted in concrete changes (that they knew about or could see) that would help protect their health and safety. These seemed to be disincentives to reporting since workers did not see a point in reporting if nothing changed as a result.

It appeared that transparency of outcomes after reporting depended in part on a worker’s supervisor. Some workers said that there was always debriefing, discussion and follow-up after incidents, while others said there was none. This depended on how important the supervisor considered debriefing to be, as well as other factors such as workload and time. Follow-up with the worker appeared to happen more consistently when an assault resulted in an injury.

Some management participants discussed challenges with follow-up and information sharing when the reported incident related to horizontal violence or harassment. Some were not sure how much information could be shared with the individual that filed the report, while still protecting the privacy of the other worker involved in the incident.

Finally, some workers felt there was a degree of stigma and fear associated with reporting of incidents. They reported feeling that when debriefing happened there was a focus on what the worker could have done differently to prevent the incident,

instead of a more holistic approach that considered a range of factors. Workers worried that being involved in a workplace violence incident would be viewed by management as a shortcoming in their own training or clinical skill.

> *"I mean, sometimes it really comes down to concerns about what happens if I report. Is it sort of more concern about me and my performance as opposed to trying to understand the incident and how do we prevent that going forward. Sometimes people just don't know what the process is, or the process seems kind of cumbersome so it's easier not to report and hope it doesn't happen again." [Cindy, External Key Informant]*

Broader issues

There were a number of broader issues that affected the implementation of violence prevention policies and programs across hospitals.

Legislative gaps

A number of external stakeholders and hospital participants reported that vagueness in the violence prevention legislation meant that there was a lack of guidance and clarity about how certain activities were to be carried out. An example also noted earlier was the lack of clarity on how risk assessments were to be carried out, how often, what they should involve and who should participate. In practical terms, this meant that the quality and nature of violence prevention activities could vary widely by hospital. Some participants suggested that the legislation should be more prescriptive and more consistently implemented, and in addition, there should be more information available to hospitals about best practices when it comes to violence prevention programming.

Culture

There was general agreement that a cultural shift had occurred in hospitals.

> *"I think before it was more…I want to say, acceptable. Acceptable is not the right word, but if a patient hauled off and slugged you, oh well, that was just part of your job, the risk of your job, and you didn't do anything about it or think anything about it." [Focus group participant, Site 2]*

Most participants did not view violence as a normal or acceptable part of their jobs. However, a strong theme that emerged from focus groups and interviews related to the intent of a violent act. Some workers struggled with flagging and reporting patients who were violent but did not intend malice. Arguably, the purpose of flagging and reporting policies was not to punish these patients, but to protect workers from violent acts (intentional or not). Yet, acts viewed as unintentional were more likely to be overlooked and even accepted by staff.

Other aspects of the workplace culture also seemed to have an impact on workplace violence. For example, study participants noted that a “patients first” stance, which afforded patients greater access to some areas of the hospital and allowed for longer visiting hours, had an impact on how patient-initiated violence was regarded and dealt with. For example, one participant described how the person who assaulted her was given an opportunity to explain “his side of the story” which made her feel unsupported after the event. Another worker questioned why visitors who assaulted staff were simply removed from the hospital instead of being charged by police with assault. It seemed that a number of subcultures co-exist in hospitals. These subcultures appear to be created through many policies, programs and the actions of leaders in an organization, and are ever-evolving. Some of these subcultures may contribute to a latent acceptance of violence in hospitals.

Time and resources

Time and resources were repeatedly raised as important issues by both staff and management. Participants noted that resource constraints had a direct bearing on the implementation of violence prevention and management activities. High workloads and understaffing made it more difficult for staff to adopt new work practices learned through training or to implement safety precautions requiring multiple individuals. Many workers discussed not having adequate time for reporting or comprehensive debriefing after an incident. Some participants discussed efforts to keep certain components of violence prevention programs intact and expressed concern that a lack of resources was a key barrier to maintaining violence prevention activities in the long term.

> *“So, lack of training, lack of resources, also workload…workload is a big thing because if somebody is over-tasked, is working too much, there is a lot of overtime going on because of, again,*

money, budgets, staff might not be as creative with avoiding conflict. Patients might get upset because of workload, having to wait over two hours. It's just not a good recipe. It's a recipe for disaster, actually. That also promotes the lateral, internal violence, too, or conflict." [Sue, Site 1 Nurse]

Differing management–worker perspectives

At all the sites, we found a degree of discordance between management and worker perspectives about certain aspects of violence prevention programs and approaches. In some cases, there was disagreement about how well a program was working in practice. Other times we were given contradictory information about program details. Finally, there were sometimes disagreements about culture or work environments, for example, about whether reporting was truly encouraged or not. There are a number of possible explanations for this. It is possible that senior management may wish to put their "best foot forward" when discussing certain practices and policies and there may be some resistance to highlighting gaps or shortcomings. Managers, particularly when they do not spend a lot of time interacting with patients, may not have a good understanding of how policies work in practice. Workers also may not be aware of all management activity. For example, a worker may assume that nothing was done after a report was filed when in fact the report led to a higher-level change.

Supervisors

Supervisors played an important role in enacting policy and programs. For example, we found that depending on the stance of the supervisor, workers' experiences of violence prevention programs could be vastly different, even within one hospital. One supervisor might debrief with workers after violent incidents, seek input about how violence can be prevented and support reporting by giving this activity time and priority during work hours. Another might brush off incidents without discussion and expect staff to file reports on their own time.

Physical space

Environmental and structural features of hospitals were noted as being relevant to implementing workplace violence legislation. It was costly to retrofit older buildings to improve safety and in some older buildings staff did not have access to particular

violence prevention measures. For example, at one site the GPS on personal alarms did not work in the older buildings. At another site, door alarms on doors that were to be kept locked were not installed because it was too costly to make changes. Because conditions of buildings (and sites) were not uniform across hospitals, this meant that safety measures, even within one hospital, were often not consistent.

Size and location

The size and location of a hospital appeared to be relevant to the implementation of violence prevention measures. The larger hospitals in our study had more staff devoted to the development of a violence prevention program. The small hospital in our study had fewer resources to put toward violence prevention.

As we noted earlier, the latter hospital was the only site that did not have a security team; instead, workers depended on a team of maintenance personnel for security or the police when needed. There were several issues raised by workers related to this. Maintenance team staff were not scheduled in the night time and, due to hospital size, numbers of staff working the night shift were small. Workers noted that they were often working with just one other person at night and when that person was occupied or on break they were alone. Fewer police officers were available in the smaller community which meant longer response times when they were already dealing with another matter. In addition, because it was police responding to calls, workers only called them when absolutely necessary. Factors in the external community, such as a lack of anonymity, also made workers reluctant to report incidents. In general, both workers and management described the hospital as safe and said rates of violence were low. However, in focus groups, we heard that a lack services in the surrounding community meant that they were seeing patients who sometimes had serious mental health and addiction issues. There was little money for infrastructure—like installing better lighting in the parking lot. In focus groups, workers also described situations where they were hit, pushed and threatened; yet many of these incidents, we were told, were not reported.

Considerations for Decision-Makers

In synthesizing the study findings, there emerge a number factors that hospital management and staff might consider when developing, planning, implementing and reviewing their violence prevention programs. These are outlined below.

Considerations for violence prevention program planning and review

Training

Training content may change as programs and approaches to violence prevention evolve and mature. Current areas where enhancement of training may be needed include self-defence and de-escalation techniques and horizontal violence. As each hospital unit is unique, encouraging regular staff feedback about training to address their day to day situations could aid in determining training needs and scheduling for refresher training. Refresher courses for staff are particularly important when knowledge, policies or best practices have changed. While online training is convenient, there may be drawbacks to moving most or all training online. In-person training allows for hands-on practice and could increase knowledge retention. A training program might also include an assessment of training needs for others interacting with patients or family, including volunteers, temporary staff and students.

Organizational risk assessment

Hospitals may wish to seek additional information about ways to conduct comprehensive risk assessments (proactive and reactive). Those wishing to learn more may find it helpful to start with existing resources such as the Public Services Health and Safety Association toolkit. Hospitals may also benefit from training on identifying root causes and triggers for violence. Risk assessments can benefit from the involvement of frontline staff as well as the development and communication of a concrete action plan that includes both short-term and longer-term goals.

Flagging

Additional attention to the complexity of flagging issues may be an important part of violence prevention activities. Hospitals may want to consider developing flagging procedures adapted to different units (in-patient vs. out-patient) and for use in different situations (patient, family or friend) as well as a graded flagging approach

for different levels or triggers of incidents. Developing a process for a clear follow-up plan for when a flag is put in place can be helpful. Various methods could be implemented to alert workers of a flag, including workers with limited access to computer records (e.g. electronic icon, bracelet, door sign). It may also be useful to make flagging processes clearer to patients and family members. One hospital had developed a pamphlet describing flagging for family members. Hospitals can refer to privacy legislation and hospital standards in order to develop flagging procedures that promote safety while meeting privacy requirements.

Summoning assistance

Dedicated, well-trained code white teams can be a great resource for workers. However, technology to summon assistance is most useful if regularly tested to ensure it is reliable and working in all parts of the hospital. If it is not, other measures will be needed to ensure workers can summon assistance. One hospital had integrated an alarm into their communication system and this meant that the technology was regularly used and tested. Once an alarm is activated or a code white is called, all parties responding should understand their roles (e.g. who takes the lead, who files a report, etc.).

Security

Although costly, workers and some senior management described several benefits of on-site, in-house (not contracted out) security for violence prevention. Regardless of who provides the services, violence prevention and incident response may be more effective when the role of security is transparent and clearly communicated to all staff (e.g. who takes the lead when a code white is called, is security permitted to “lay hands” on patients, etc.). Training in violence prevention was described as a key component of effective security teams.

Reporting

It is important to remember that reports of violence and harassment do not always provide a reliable estimate of actual incidence of events. Examining barriers that hinder reporting can produce the information needed for making improvements to the process. As much as possible, reporting systems should be streamlined, simplified and flexible (e.g. allowing for shorter reports for less serious incidents, removing word limits, access to computers for e-reporting). Staff can often provide valuable

advice about what would support reporting of workplace violence. Discussions with staff can also highlight how reporting may inadvertently be discouraged (e.g. workers feeling like nothing comes of reporting or workers feeling blamed for the incident). Hospitals can foster a culture of reporting by facilitating reporting during work hours and ensuring that supervisors support reporting. Incident analysis that considers root causes, environmental factors, training management role and hospital processes can be an important part of the reporting procedure. Follow-up is also important and it may be useful to include staff input on corrective and preventive actions and communication plans.

Considerations for violence prevention program development

Hospitals are large, complex organizations. When designing workplace violence prevention programs, examining the work and needs of different departments and staff will provide important information. Investment in violence prevention sends a strong message about how seriously hospitals view the problem of workplace violence. Commitment of resources (e.g. personal alarms) or staff time (e.g. a dedicated violence prevention role) convey the message that violence prevention is not “just talk.”

Input from workers who provide frontline healthcare and those in non-clinical roles can provide valuable insight into designing and implementing violence prevention programs. Discordant views and experiences suggest a need for improved dialogue between workers and management and transparency with regard to program design and implementation. Hospital management can gain greater value by seeking out workers with diverse perspectives and experiences to participate in violence prevention planning and implementation activities.

Robust horizontal violence policies and processes are an important component of violence prevention programs that may be overlooked. When staff and management speak openly about harassment and bullying, it can make these issues less taboo. It may also be necessary to examine different policies and procedures (e.g. reporting, debriefing) to ensure that they effectively deal with incidents of horizontal violence and harassment.

The critical role of supervisors in ensuring the consistent implementation of the violence prevention program requires particular attention. This could be addressed through the development of procedures and training specifically for supervisors.

Communication with and outreach to police and the broader community may be useful on issues related to the prevention of workplace violence and external practices that either endanger or protect hospital workers. Furthermore, communication with other hospitals and, in particular, opportunities to share experiences with other hospitals about best practices, incidents and near misses could be beneficial during the development and evaluation of violence prevention programs. To assist in this regard, hospitals could also consider using resources already developed by other organizations, such as the Public Services Health and Safety Association, when carrying out risk assessments or developing flagging protocols.

Considerations for violence prevention initiatives at the healthcare system level

Hospitals are quite diverse work settings. However, if similar mechanisms for collecting data about workplace violence incidence and severity were created across hospitals, the information obtained could be used to examine the effectiveness of particular violence prevention practices and policies.

Little is known about how community-based organizations providing healthcare implement violence prevention measures, and this study focussed on acute care hospital experiences. However, while the specific challenges and needs may tend to differ between the two types of organization and there may be additional considerations in the community care sector, the general considerations offered above may prove useful in the development of violence prevention programs at a wide range of organizations.

Successfully sustaining violence prevention practices in the long term will likely require specific attention. Small hospitals may need access to funding and other resources that would help them create comprehensive and sustainable violence prevention programs. Other considerations may involve: having a dedicated staff person to coordinate efforts of various departments and committees in the hospital; an investment in the monitoring and evaluation of violence prevention activities; expansion of occupational health and safety departments; and increasing accountability of the board of directors and senior management when it comes to violence prevention.

"How do we, as organizations, employers, sustain this work without any funding? I think that it's important. The one thing I always say in all of my meetings is, nothing is more important than safety. And people look at me and say 'What?' And I'm like really, how could anyone work if they don't feel safe? They can't. They can't fully focus. And, really, we want people to come to work, do a great job, and go home safe. And I think that this issue of workplace violence is so, so important. But my question to the ministries will be, how are they supporting us to sustain this great work?" [Sia, Site 2 Senior Management]

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