



Implementing violence prevention legislation in hospitals

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An Institute for Work & Health study examined the process of implementing violence prevention legislation in acute-care hospitals in Ontario. This stakeholder briefing summarizes the findings.

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 use 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 front-line clinical staff (nurses, allied health workers, social workers; N=64) and non-clinical staff (food service, security and laboratory workers; N=44).

Additionally, there were some front-line clinical staff who were interviewed (N=9) since they 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 such as the Lori Dupont murder, legislative changes, workplace inspections and lobbying by groups like the Ontario Nurses’ Association 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. 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 on-line training, which some staff felt did not adequately prepare them for real-life scenarios and made information retention difficult.



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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 (PSHSA) 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 an order) rather than proactive.

Flagging

Patient flagging was a contentious issue. 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.

Alarms

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 once 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 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).

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 front-line staff into the development of programs and policies, as well as regular check-ins, would ensure that policies 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 among hospitals would be valuable, providing them opportunities to discuss best practices and learn from incidents and near misses.



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For a copy of the full report, or for more information, please contact the principal investigator, Dr. Agnieszka Kosny, at: akosny@iwh.on.ca

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