



ONTARIO NURSES' ASSOCIATION

# Workplace Violence and Harassment

## A Guide for ONA Members

March 2025

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The Ontario Nurses' Association (ONA) is the union representing 68,000 front-line registered nurses and health-care professionals, as well as more than 18,000 nursing student affiliates providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

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## ONA STATEMENT OF BELIEFS – OCCUPATIONAL HEALTH AND SAFETY

The Ontario Nurses' Association (ONA) believes it is the right of all its members to work in a healthy and safe work environment. ONA further believes in the pursuit of the highest degree of physical, mental and social well-being of workers in all occupations. As one of the largest health care unions in the province and in the country, ONA believes it is part of its mandate to exercise a strong leadership role in achieving progressively greater gains in the field of occupational health and safety.

## ONA POSITION – VIOLENCE/HARASSMENT

In November 2005, operating room nurse and ONA member Lori Dupont was brutally murdered at Windsor's Hotel-Dieu Grace Hospital by an anesthetist who was her ex-partner and colleague. ONA members were horrified by the murder of Lori Dupont and the inquest into her death revealed that she paid the price for a culture of indifference and inattention to violence in health-care workplaces across the province. Over a decade has now passed since Lori's murder, and health-care workers continue to be among those at highest risk for workplace violence. We still need more effective action to protect them from harm.

As a result of ONA and the labour movement pressuring the government for violence/harassment legislation, the *OHSA* was amended in 2010 to explicitly require employers to take every precaution reasonable in the circumstances to protect our members from physical violence and threats of physical violence in the workplace, whether the violence originates at work or enters the workplace from outside.

The amended legislation also required employers to develop a harassment policy, program and training, but fell short by not requiring employers to take every precaution reasonable in the circumstance for the protection of workers from harassment. Further amendments in September 2016 expand harassment provisions, to include a new "workplace sexual harassment" definition that explicitly recognizes sexual harassment as part of workplace harassment. The requirement to inform the person who complained of harassment "of the results of the investigation and of any corrective action that has been taken or that will be taken as a result of the investigation," was added in 2016. Even with the amendment, the law still does not explicitly require employers to *prevent* harassment. The legislation also still does not

explicitly protect workers from psychological harm that results from exposure to violence or harassment.

It is ONA's position that in circumstances where the employer/supervisor is aware of a potential or known violence hazard and does not take every precaution reasonable for the protection of our members, the employer and supervisor are in violation of the *Occupational Health and Safety Act (OHSA)* and should be held accountable. ONA will continue to strive for progressive gains in the area of collective bargaining for all our members and continue to lobby the government to expand violence/harassment legislation that protects our members from psychological harm.

ONA members must take strong leadership roles in removing violence/harassment from the workplace by exercising their rights and pressing for enforcement of the *OHSA* and collective agreements. Nothing can bring Lori Dupont back, but if we hold our employers accountable and ensure enforcement of legislation something positive can come from her death.

This will only be achieved if our members:

- Report all hazards, assaults, injuries and illnesses, no matter how minor, in writing to your employer/supervisor.
- Seek immediate medical attention and ask your doctor to submit a Form 8 to the Workplace Safety and Insurance Board for all injuries and illnesses (no matter how minor).
- Advise your Joint Health and Safety Committee (JHSC) or health and safety representative (HSR) (for workplaces with 6-19 workers) of any and all unresolved issues.
- Quickly escalate all unresolved health and safety issues to the CEO or most senior executive (see Appendix H).
- Where there is no immediate action or insufficient action to protect your safety or the safety of your colleagues, have the JHSC and/or union call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD) (see Appendix J) and complain that your employer is not taking every precaution reasonable in the circumstances for the protection of a worker.

ONA members need to be aware that violent incidents are **NOT** part of the job and that there is zero tolerance for workplace violence. All ONA members have a right to a safe, violence-free workplace.

## OBJECTIVES OF THIS GUIDE

The objectives of *Violence/Harassment in the Workplace: A Guide for ONA Members* are:

- Provide ONA members, ONA representatives and JHSC members or the HSR (in workplaces with a total of six to 19 workers) with an understanding of the definition and scope of workplace violence/harassment under the *Occupational Health and Safety Act (OHSA)*.
- Provide ONA members, ONA representatives, JHSC members and HSRs with information about what they can do to stop violence against our members and address workplace harassment.
- Provide ONA representatives, JHSC members and HSRs with the knowledge and tools needed to address and advance the issue of violence to the employer and/or the Ministry of Labour, Immigration, Training and Skills Development (MLITSD).
- Provide ONA members, ONA representatives, JHSC members and HSRs with guidance on how to deal with workplace violence when it occurs and after it has occurred.
- Provide ONA members, ONA representatives, JHSC members and HSRs with valuable tools and a list of resources.

We hope this guide will help you address workplace violence/harassment with your employer and eradicate it from your workplace.

Throughout this guide, the text refers regularly to "nurses" rather than to other categories of health-care workers. To date, most of the studies, articles and statistics dealing with violence in health care facilities have been examining violence and nursing. However, we know from work conducted by ONA and other unions and through anecdotal information that workplace violence affects all categories of health care workers. Therefore, the information contained in this guide is applicable to all health care workers and will be useful to any union members in any sector facing the problem of violence/harassment in their workplaces.

## WORKPLACE VIOLENCE

### Definition

The *OHSA* 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.

This definition was incorporated into the legislation as part of a package of amendments in June 2010. These amendments also included the introduction of explicit reference to “workplace harassment” in the *OHSA*. In September 2016, further amendments enhanced these provisions to include “workplace sexual harassment” and to require employers to develop harassment programs in consultation with JHSCs and investigate harassment complaints.

The law explicitly requires the employer to take every reasonable precaution to prevent “physical injury” from “physical force” or threats of physical force, but there is still no explicit mention of “psychological injury” either from “physical force,” threats of “physical force” or other aggressive behaviour.

Also, while employers are clearly required to conduct *violence* risk assessments, there is no similar requirement to conduct assessments of the risk of *harassment*, even though harassment has been found to be a precursor to violence. And, the definition of “workplace harassment” in the Act talks only about a “*course of vexatious conduct*” from a perpetrator, and does not explicitly address single, egregious acts of harassment save for “a sexual solicitation or advance.”

As such, ONA believes all employers should develop a workplace violence policy that extends beyond the minimum requirements of the *OHSA*. Workplace policies should address all forms of aggression and should also have a goal of protecting workers from psychological harm/illness as well as from physical injury.

It is important to note that in many circumstances there is a progression in the way that abusive behaviour can escalate to aggression and even to violence. We recognize that not every single act of abuse will lead to an act of violence but want members to understand that the possibility of progression from one to another does exist. The progression can graduate from verbal to physical assault, notwithstanding that there are occasions when physical abuse may occur suddenly, without a series of prior escalating incidents of abuse.

## **Examples of Workplace Violence**

Incidents that can constitute or can escalate into workplace violence include, but are not limited to, the following:

- Assault.
- Domestic Violence.
- Bullying.
- Harassment.
- Psychological abuse.
- Sexual abuse up to and including assault.
- Threats.
- Verbal abuse.

## **Categories**

There are four main categories of workplace violence:

- External – (thefts, vandalism, assaults by a person with no relationship to the workplace).
- Client/Customer – (physical or verbal assault towards an employee by a client/family member or customer).
- Employment related: The violent person (physical or verbal) has or had some type of job- related involvement with the workplace.
- Domestic Violence (Personal Relationship).



## Who Tends to be the Most at Risk from Workplace Violence?

- Health-care employees.
- Correctional officers.
- Social services employees.
- Teachers.
- Municipal housing inspectors.
- Public works employees.
- Retail employees.

(Canadian Centre for Occupational Health and Safety [CCOHS], n.d.)

According to Pompeii et al (2015), p. 1200, “Most workgroups involved in direct patient care were at considerable risk of violence. Nurses had the highest prevalence followed by nurses’ aides, and physicians/nurse practitioners/physician assistants.” (as cited in Findorff et al., 2005).

## Where Can Violence Occur?

Violence in the workplace is a hazard confronted by nurses working in all health-care sectors. Staff in emergency departments face the same kinds of problems with violent patients as do staff in psychiatric settings.

According to the National Institute for Occupational Safety and Health (NIOSH), “Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk.” (NIOSH, 2002 p. 3.) In fact, by 2009 an ICN Fact Sheet reported “General treatment rooms have replaced psychiatric units as the second-most frequent area for assaults.” Assault rates are also high in long-term care homes and facilities for the mentally/cognitively impaired. A 2014 American study by Edward, Ousey, Warelow & Lui found physical aggression most frequent in mental health, emergency departments and nursing homes. Nurses working in the community frequently take emergency calls in the evening and at night, and often visit clients whom they have never met, in their homes. Often, these visits take them to high-crime neighbourhoods.

## What are the Effects of Violence?

The effects of violence can range in intensity and include the following:

- Minor physical injuries.
- Serious physical injuries.
- Temporary and permanent physical disability.
- Psychological trauma.
- Death.

According to 2017 Workplace Safety and Insurance Board (WSIB) statistics, WSIB recognized six per cent more violence-related physical injuries to health-care workers than in the previous year, 2016. Furthermore, health-care workers were seven times more likely than manufacturing workers to be physically injured from violence, 45 times more likely than construction workers, and at least 860 times more likely than miners.

These statistics only reflect lost-time injuries that have been reported and accepted by the WSIB in 2017 and also do not reflect psychological injuries from violence in which WSIB did not pay benefits. But according to the findings of the above cited-article by Edward et al, (2014) nurses exposed to physical or verbal abuse also “often experienced a negative psychological impact post incident.” (p. 653)

On May 8, 2018, Bill 31, the *Plan for Care and Opportunity Act (Budget Measures)* received Royal Assent to include nurses, who provide direct patient care and suffer from post-traumatic stress disorder (PTSD), in the *Workplace Safety and Insurance Act* presumptive legislation. This legislation is intended to expedite access to benefits, resources and timely treatment through the implementation of a presumption that PTSD is work-related.

Front-line nurses who are first responders face traumatic situations and are more likely to suffer PTSD. These situations include violence at work, death of a child particularly due to abuse, death or injury of patients, heavy patient workloads and treating patients that resemble family or friends.

PTSD involves clinically significant distress and impairment to functioning, and the development of certain types of symptoms following exposure to one or more traumatic events. It can include painful flashbacks, outbursts, thoughts of suicide and feelings of worry, guilt or sadness. With the new presumption, once a front-line

nurse is diagnosed with PTSD by either a psychiatrist or a psychologist, it is supposed to be presumed that the PTSD arose out of and in the course of the workplace. The presumption positively impacts up to 140,000 nurses in Ontario.

Violence may also have negative organizational outcomes, such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and co-workers and a hostile working environment. The Occupational Health Clinics for Ontario Workers (OHCOW) “Mental Injury Tools for Ontario Workers” cites violence and the threat of it as one cause of workplace psychological injury that has a stunning impact on workplaces around the world.

## WORKPLACE HARASSMENT

### Definition

The *OHSA* defines “workplace harassment.”

“Workplace harassment” in the *OHSA* “means a) 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, or b) workplace sexual harassment.”

“Workplace sexual harassment” in the *OHSA* “means (a) engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome, or

(b) making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome”

The *Ontario Human Rights Code (OHRC)* still prohibits harassment at work and elsewhere, but that legislation is restricted to harassment based only on specific prohibited grounds, such as race, religion, disability and sex. Harassment unrelated to the specific grounds (e.g. bullying based on personal dislike) is not covered by the *OHRC*. Most employers will already have policies and complaint procedures in

place that address harassment based on the prohibited grounds of discrimination in the *OHRC*, such as race, religion, disability and sex.

The 2010 and 2016 amendments to the *OHS*A extend the reach of law with respect to harassment at work. Unlike the *OHRC*, the new provisions of the *OHS*A will apply no matter what the reason for the harassment, including “sexual harassment.” Since June 15, 2010, the *OHS*A has addressed “non-Code” harassment and with the 2016 amendments, employers are required to establish a harassment policy and, in consultation with the *JHSC*, develop and maintain a written program to implement the policy.

The program must include measures and procedures for workers to report incidents of workplace harassment to the employer or supervisor, how the incidents or complaints will be investigated, and how the worker will be informed of the results of the investigation. Also included is any corrective action that has been taken or that will be taken as a result of the investigation. The law also requires that the employer ensure investigation of incidents and complaints of harassment, and that the complainant and the alleged harasser are informed in writing of the results of the investigation, and any corrective action that has been taken or that will be taken as a result of the investigation.

The employer must also provide information and instruction to all workers on the contents of the policy and program. It does not explicitly require the employer to take every precaution to protect workers from harassment.

Workplace harassment may include teasing, intimidation or offensive jokes or innuendos, displaying or circulating offensive pictures or materials, or offensive or intimidating phone calls.

Bullying is a form of workplace harassment. Bullying is usually intentional in nature and an attempt to exert power or control over the target.

In some cases, it may be appropriate for a member to file complaints under both the employer’s human rights harassment policy and this health and safety harassment policy. *ONA* members should request the assistance of the Bargaining Unit President/Labour Relations Officer (*LRO*) when making a complaint of harassment. The union will ensure the appropriate policies are utilized and the full range of remedies is requested. The union will also determine whether a grievance should be filed.

## Enforcement

MLITSD inspectors are expected to enforce workplace harassment provisions in the OHS Act and, as of September 2016, are empowered to order an employer to investigate incidents or complaints and to engage, at its own expense, a third-party to conduct a workplace harassment investigation. Unfortunately, a harassment investigation report is not considered, “a report respecting occupational health and safety,” that is to be shared with the JHSC. We still do not expect inspectors to issue orders about *preventing* actual harassment.

## OVERVIEW OF OHS ACT PROVISIONS REGARDING WORKPLACE VIOLENCE AND HARASSMENT

“Workplace violence” and “workplace harassment” and “workplace sexual harassment” are defined.

*For Definition of “Workplace Violence” see page 4.*

*For Definitions of “Workplace Harassment” and “Workplace Sexual Harassment” see page 7.*

## Employer Obligations

The employer must:

- Prepare written policies with respect to workplace violence and harassment.
- Post copies of the policies in a conspicuous place in the workplace (where there are more than five workers).
- Review the policies as often as is necessary, but at least annually.
- Develop and maintain a program to implement the policy with respect to workplace violence.
- Assess the risks of workplace violence that may arise from the nature of the workplace, the type of work or the conditions of work.

- Advise the JHSC or HSR of the results of the assessment and provide a copy if the assessment is in writing. Where there is no JHSC or HSR, provide a copy to workers on request or advise the workers how to obtain copies.
- Reassess the risks of workplace violence as often as is necessary to ensure the violence policy and program continue to protect workers from workplace violence, advise the JHSC or HSR of the results of the assessment and provide a copy if the assessment is in writing. Where there is no JHSC or HSR, provide a copy to workers on request or advise the workers how to obtain copies.
- Provide information to a worker, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour, if the worker can encounter that person in the course of work and the risk of workplace violence is likely to expose the worker to physical injury.
- Provide information and instruction that is appropriate for the worker on the contents of the policy and program with respect to workplace violence.

Hospital and long-term care home employers under the Health Care and Residential Facilities Regulation must also provide, in consultation with the JHSC or HSR, training and educational programs to workers. Therefore, just providing information and instruction is not enough to comply with Section 9 (4) of this regulation.

The violence program shall:

- Include measures and procedures to control the risks identified in the risk assessment as likely to expose a worker to physical injury.
- Include measures and procedures for summoning immediate assistance when workplace violence occurs or is likely to occur.
- Include measures and procedures for workers to report incidents of workplace violence to the employer or supervisor, including threats.
- Set out how the employer will investigate and deal with incidents or complaints of workplace violence, including threats.
- Provide a worker with information and instruction that is appropriate for the worker on the contents of the policy and program with respect to workplace violence.

## Workplace Harassment Program

The employer must:

- Develop and maintain a program to implement the policy with respect to workplace harassment.
- In consultation with the JHSC, develop and maintain the written program to implement the policy and review at least annually.
- Include measures and procedures for workers to report incidents of workplace harassment to the employer or supervisor including measures and procedures for workers to report incidents of workplace harassment to a person other than the employer or supervisor, if the employer or supervisor is the alleged harasser.
- Set out how the employer will investigate and deal with incidents and complaints.
- Ensure that a harassment investigation is conducted into incidents and complaints.
- Set out how to keep confidential information obtained about an incident or complaint of workplace harassment, including identifying information about any individuals involved. That is, unless the disclosure is necessary for the purposes of investigating or taking corrective action with respect to the incident or complaint, or as otherwise required by law, and how the complainant and alleged harasser will be informed of investigation results and any resulting corrective action.
- The complainant and alleged harasser will be informed in writing of the results of the investigation and of any corrective action that has been taken or that will be taken as a result of the investigation.
- Provide workers with information and instruction on the policy and program contents.

Hospital and long-term care home employers under the Health Care and Residential Facilities Regulation must also provide, in consultation with the JHSC or HSR, training and educational programs to workers. Therefore, just providing information and instruction is not enough to comply with Section 9 (4) of this regulation.

## Specific Sections of the *OHSA*

Section 32.0.5 (1): “For greater certainty, the employer duties set out in Section 25, the supervisor duties set out in section 27, and the worker duties set out in section 28 apply, as appropriate, with respect to workplace violence.”

This provision makes it clear the employer’s and supervisor’s requirements to take every precaution reasonable in the circumstances for the protection of a worker, apply to workplace violence as defined in the *OHSA*. There is no similar repetition of the employer/supervisor need to take precautions to protect against workplace harassment even though MLITSD acknowledges that harassment may be a precursor to violence.

32.0.7 (1) To protect a worker from workplace harassment, an employer shall ensure that

- a) an investigation is conducted into incidents and complaints of workplace harassment that is appropriate in the circumstances;
- b) the worker who has allegedly experienced workplace harassment and the alleged harasser, if a worker of the employer, are informed in writing of the results of the investigation and of any corrective action that has been taken or that will be taken as a result of the investigation;

Section 32.0.7 (2): “The results of an investigation under clause (1) (a), and any report created in the course of or for the purposes of the investigation, are not a report respecting occupational health and safety for the purposes of subsection 25 (2).”

ONA believes these provisions do not honour the right for JHSCs to know about workplace hazards and doesn’t help a committee exercise its power to identify and assess hazards and make recommendations to protect all workers. As well, these provisions help isolate a victim from access to the usual worker support in health and safety matters offered by JHSCs and unions.



## Domestic Violence Spillover to Workplace

The coroner's jury from the inquest into the death of ONA member Lori Dupont made recommendations about preventing similar tragedies. It recommended employers be made to take steps when aware of domestic violence threats reaching into the workplace.

The *OHSA* requires employers to take every precaution reasonable in the circumstances to protect workers from exposure to domestic violence that may cause physical injury in the workplace. A reasonable precaution could involve creating an individual safety plan for the worker while they are in the workplace. The safety plan should be developed in consultation with the targeted worker, the union and the JHSC. The Public Services Health and Safety Association (PSHSA) has a Safety Plan Toolkit available at <https://www.pshsa.ca/resources/hospital-resources-workplace-violence-prevention-for-the-healthcare-sector>.

## Disclosure of Personal Information of Persons with History of Violent Behaviour

The employer has a duty to provide information to a worker about a person with a history of violent behaviour if the worker can be expected to encounter that person in the course of work, and “the risk of workplace violence is likely to expose the worker to physical injury.” The disclosure requirement is limited to no more personal information “than is reasonably necessary to protect the worker from physical injury.”

This section has implications for patients/residents/clients and their relatives, as well as colleagues who have displayed violent behaviour in the past. For MLITSD's explanation of what information needs to be conveyed about such a person, refer to Section 2.6, page 19 of MLITSD's guideline document, *Workplace Violence and Harassment: Understanding the Law*, which is available via links in the Health and Safety Section of ONA's website at [www.ona.org](http://www.ona.org) for more information.

## Work Refusals

Workers who believe they are at risk of physical injury from workplace violence may refuse to work, and MLITSD is expected to respond as needed in accordance with the work refusal provision (Section 43) of the *OHSA*. The limited right to refuse for certain workers described in Section 43 (2) continues. For more information on work

refusals and the limited right to refuse unsafe work for many of our members, refer to ONA's *Right to Refuse Guide* and a Section 21 (MLITSD's advisory committee) Guidance Note entitled, "Right to Refuse Unsafe Work," both of which can be found on ONA's website at [www.ona.org](http://www.ona.org).

## Notice/Reporting Requirement

There is a clear requirement for the workplace's JHSC or HSR, trade union and MLITSD, as applicable, to be notified by the employer if a worker is disabled from performing their usual work **or** needs medical attention due to workplace violence (*OHS*A, Section 52). Also see Section 21 Guidance Note entitled, "Occupational Injury and Illness reporting Requirements," found on ONA's website at [www.ona.org](http://www.ona.org)

## Psychological Injury

ONA and others have so far been unsuccessful in persuading the government to explicitly include psychological injury from violence in the *OHS*A. Nevertheless, under the notice provisions of the *OHS*A and regulations, an employer will still be required to report to the MLITSD, union and JHSC any disabling psychological injury or illness from the workplace, including such injury or illness from workplace harassment or violence. In fact, under Section 52 (2) of the *OHS*A, if an employer is advised by or on behalf of a worker that the worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the WSIB by or on behalf of the worker, the employer must give notice to the parties above within four days of being advised.

## Enforcement

MLITSD inspectors are to enforce the workplace violence and harassment provisions in the *OHS*A.

The employer is required to establish a violence policy, conduct violence risk assessments, and develop a program of measures and procedures to report, investigate and deal with incidents of workplace violence, for summoning immediate assistance when workplace violence occurs or is likely to occur and control risks of violence as identified in the risk assessment. We expect MLITSD inspectors to issue orders when employers and supervisors do not take every precaution reasonable in the circumstances to control workers' risk of exposure to violence and do not demonstrate that they are competent under the *OHS*A and its regulations. We also

expect MLITSD inspectors to respond when violence triggers a work refusal that is not resolved by the workplace parties.

We also expect inspectors to ensure the employer develops and maintains harassment policies and accompanying programs in consultation with JHSCs. They should look to ensure the employer conducts an investigation and, if not, can order the employer to engage a third party to investigate at the employer's expense. In addition, inspectors can see that employers provide workers with harassment policy and program information and instruction.

The police will continue to deal with violent individuals and matters under the *Criminal Code of Canada (CCC)*.

For an employer's minimum requirements checklist, please see Appendix B.

## THE STATISTICS

ONA members are in the highest risk group for occupational violence in the entire workforce.

- Statistics from WorkSafe BC show 3722 health-care workers were injured by violence at work between 2005 and 2012. By comparison, the law enforcement sector saw only 241 workers injured over the same time period. The most violent assaults of health-care workers happen in emergency rooms and psychiatric wards. (Clancy, 2015)
- Female nurses have about 21 per cent greater odds of verbal abuse from patients/relatives or staff than male nurses. Male nurses have about 18 per cent of greater odds of physical abuse from patients/relatives or staff than female nurses. (Edward, Stephenson, Ousey, Lui, Warelw & Giandinoto, 2016, p. 289)
- Mental health nurses have about three times the odds of physical assault from patients/relatives or staff than nurses in non-psychiatric/mental health settings. (Edward et al, 2016, p.289)
- Workplace violence is a serious problem for nurses working in the hospital setting. Of the occupations measured in a recent study, those working in medical occupations had the third highest proportion (10 per cent) of workplace violence (Speroni, Fitch, Dawson, Dugan & Atherton, 2013, p. 3, as cited in US Department of Justice, n.d.).

## Injury Statistics

- The top five occupations reporting 77.62 per cent of violence-related injuries in health care are: nurses' aids and orderlies; community and social service workers; registered nurses; registered nursing assistants; and visiting homemakers, housekeepers, and related occupations (WSIB Enterprise Information Warehouse [EIW] Claim Cost Analysis Schema, March 2019 data snapshot).
- Violence claims made up 12.7 per cent of total lost-time injuries in health care (WSIB EIW Claim Cost Analysis Schema, March 2019 data snapshot).
- In the Hospital class for 2021, the allowed WSIB claim count for "assaults, violent acts, harassment and acts of war or terrorism" was 501, with 29 days lost per claim on average. For 2022, the claim count climbed to 543, with 20 days lost per claim on average. The leading age group for both years was 25-29 years old (WSIB Provincial Statistics tool, February 2023 data snapshot).
- In the Nursing and Residential Care Facilities class for 2021, the allowed WSIB claim count was 481, with 27 days lost per claim on average. For 2022, the claim count climbed to 481, with 21 days lost per claim on average. The leading age group for both years was 25-29 years old (WSIB Provincial Statistics tool, February 2023 data snapshot).
- In the Ambulatory Health Care class for 2021, the allowed WSIB claim count was 118, with 41 days lost per claim on average. For 2022, the claim count climbed to 120, with 23 days lost per claim on average. The leading age group was 50-54 for 2021, and 25-29 for 2022 (WSIB Provincial Statistics tool, February 2023 data snapshot).

## Frequency of Incidents

Studies and surveys indicate that workplace violence occurs frequently.

Gillespie, Gates, Kowalenko, Bresler and Succop (2014) found:

- 86 per cent (of participants in an intervention study) had been either threatened or assaulted at least once during the 18 months of data collection (p. 3).

Speroni, Fitch, Dawson, Dugan and Atherton (2014) researched the incidence of workplace violence against nurses. They found:

- Over the past year, 76 per cent experienced violence (verbal abuse by patients, 54.2 per cent; physical abuse by patients, 29.9 per cent; verbal abuse by visitors, 32.9 per cent; and physical by visitors, 3.5 per cent), such as shouting or yelling (60 per cent by patients and 35.8 per cent by visitors), swearing or cursing (53.5 per cent by patients and 24.9 per cent by visitors), grabbing (37.8 per cent by patients and 1.1 per cent by visitors), and scratching or kicking (27.4 per cent by patients and 0.8 per cent by visitors) Emergency nurses (12.1 per cent) experienced a significantly greater number of incidents (p. 218)

Byon, Sagherian, Kim, Lipscomb, Crandall and Steege found (2021):

- Overall, 44.4 per cent and 67.8 per cent of nurses reported experiencing physical violence and verbal abuse, respectively, between February and May/June 2020. Nurses who provided care for patients with COVID-19 experienced more physical violence and verbal abuse than nurses who did not care for these patients. One in 10 nurses felt reporting the incident was more difficult during the pandemic.

The International Association for Healthcare Security & Safety (IAHSS) recent health care crime survey revealed:

- Type 2 aggravated assaults accounted for 83 per cent of all aggravated assaults and 91 per cent of all assaults in U.S. hospitals. As in previous years, Workplace Violence Type 2 continues to dominate the other types of workplace violence and is increasing (VELLANI; IAHSS, 2016.)

In a recent quantitative review, Paul Spector, a professor of psychology at the University of South Florida, USA and colleagues analyzed data for more than 150,000 nurses, drawn from 160 global samples. They found:

- That overall, about a third of nurses have been physically assaulted, bullied or injured while approximately two-thirds have experienced non-physical assault (Spector, 2014, p. 73).

Survey results by ONA paint a similar picture of the prevalence of workplace violence in the nursing profession.

- 54 per cent of ONA members say they have experienced physical violence or abuse in the workplace; 85 per cent of members say they have experienced verbal abuse in the workplace, 39 per cent report other forms of violence/abuse, and 19 per cent say they have experienced sexual violence or abuse in the workplace (ONA, 2012, Dec., p. 4).

A 2012 survey Copenhagen Psychosocial Questionnaire (COPSOQ) of ONA health and safety activists revealed, “80 per cent of participants reported recent exposure to offensive workplace behavior ranging from bullying to actual physical violence” (ONA, 2012).

## **Perpetrators of Workplace Violence, Bullying and Verbal Abuse**

In a Canadian survey of nurses, O’Brien-Pallas and Whitehead (2005) asked nurses whether they had experienced any form violence in the last 10 shifts worked. They found in terms of the source of the violence:

- It was the patient who directed the aggressive behaviour at the nurse. Other sources of violence were the family/visitors, physicians, nursing co-workers, and managers being either verbally aggressive or emotionally abusive to nurses. Conversely, emotional abuse, more than any other type of violence, came from a source other than the patient. (p. 38)

Speroni, Fitch, Dawson, Dugan and Atherton (2013) found:

- 76 per cent of hospital system nurses experienced verbal and/or physical violence by a patient or visitor over the past year, and emergency nurses experienced significantly more incidents. (p. 227).

Findings from a study by Sofield and Salmond (2003) revealed:

- 91 per cent of the respondents had experienced verbal abuse in the past month. The physician was the most frequent source of verbal abuse, followed by patients, patient families, peers, supervisors, and subordinates (p. 274).

While the sources of abuse varied, the ONA 2012 survey Copenhagen Psychosocial Questionnaire (COPSOQ) of ONA health and safety activists found bullying by supervisors most strongly related to physical symptoms.

Findings from a study by Braun, Hafiz, Singh and Khan (2021) revealed:

- Among 61 HCW deaths, (34 per cent) were homicides. Among homicide perpetrators, both Type II (perpetrator was client/patient/family member) and Type IV (personal relationship to perpetrator) were equally common (33 per cent).

## **Domestic Violence – A Workplace Problem!**

Dr. Peter Jaffe, PhD, Faculty of Education and Centre for Research and Education on Violence Against Women & Children, University of Western Ontario, highlighted in his presentation (Jaffe, 2008) at the Ontario Safety Association for Community and Health care (OSACH) teleconference in 2008 the importance for employers to also address domestic violence that enters the workplace. His presentation alerted participants to evidence that domestic violence can spill over into the workplace:

- One in four women may face abuse in an intimate relationship – maybe lethal, as it is the most common form of homicide
- 70 per cent of individuals suffering from domestic violence are victimized at work
- Abusive spouses may place harassing phone calls or make unwelcome appearances at work

## **Violence is Under-reported and Under-evaluated**

The reasons for under-reporting vary, but a constant theme is that violence is considered to be “part of the job” (Speroni, Fitch, Dawson, Dugan and Atherton, 2013, p. 219, as cited in Albrecht, Gavish and Siliciano, 2008; Rosen, 2013, para. 4).

During the 1960s, a U.S. insurance industry specialist, Frank Bird (1980), devised his “accident ratio.” Bird's pyramid, as it is commonly known, shows a ratio of accident reporting of 1-10-30- 600. That means theoretically that for every reported disabling injury, there are 10 minor injuries, 30 property damage accidents and 600 incidents with no visible injury or damage (“near-miss” accidents).

This ratio does not take into account unreported incidents. Using the theoretical ratio above and the reported accident rate, we might begin to extrapolate the frequency of actual occurrences of violence.

## Summary and Conclusion of the Statistics

Studies clearly reveal that our members in all sectors are at risk of workplace violence. Health care employers have a legal responsibility to comply with occupational health and safety legislation and the violence provisions of the Act and take every precaution reasonable in the circumstances for the protection of a worker

Prevention of workplace violence can only be achieved when each and every member holds the employer accountable for their health and safety. Workers must alert their supervisors to the hazard of violence as they become aware of it; supervisors must advise workers of any actual or potential danger to their health and safety and must take every precaution reasonable in the circumstances for their protection. When the supervisor/employer does not protect a worker's safety and if time permits, the worker should contact their JHSC member or HSR and Bargaining Unit President/LRO, who should help raise the concern as high as necessary with the employer, union and government (MLITSD) and as quickly as necessary to help resolve the issue.

Where time does not permit, the worker or union should immediately call the police, if necessary, and/or call the MOL (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form for Reporting an Unresolved Safety Hazard, and resources in Appendix J) with a formal complaint advising the MLITSD of the concern they have regarding violence in the workplace and the lack of reasonable precautions to protect workers. (See Appendices A, B and C.)



## ONA CASE REPORTS

- Lori Dupont, a recovery room nurse working at Hotel-Dieu Grace Hospital in Windsor, was brutally murdered in her workplace in 2005 by an ex-partner/anesthetist working for the hospital. Lori's case is particularly tragic because of its circumstances: Lori was a vibrant 37-year-old single mother who was harassed by her ex-partner, an anesthetist who worked alongside her. Lori had saved the doctor's life in spring 2005 when she found him attempting suicide after breaking into her home. She feared him and tried to protect herself by seeking a court-ordered peace bond, and by requesting that her employer give her extra security and never schedule her to work with him. Tragically, neither the courts nor her employer were able to keep her safe.
- An emergency room (ER) nurse was attacked when a man who was in the ER as a companion to a patient felt the nurse was taking too long to administer medication to his friend. The companion hit the nurse over the head with an umbrella and chased her as she fled.
- A patient who overdosed and was lying unconscious in the ER on an old stretcher with an IV running, was given the antagonist narcan. The patient awoke immediately, jumped off the stretcher, took the IV pole out of the receptacle and started swinging it at an ER nurse. Luckily, the nurse jumped out of the way and security guards and police officers in the department secured the patient.
- A patient with a non-urgent condition, upset over having to wait several hours to be seen by a doctor, lost his temper at an ER nurse when doctors again attended to another patient requiring CPR. The non-urgent patient attempted to lunge at the nurse who was standing behind the nursing station, while screaming repeated obscenities at her. Luckily, the situation was defused by another man who was waiting for his companion to be treated in the ER.
- During a protracted outbreak of an infectious disease at a large hospital, nurses became so accustomed to death threats from frustrated members of the public and lack of preventive measures by the employer, that they stopped reporting the threats.
- In another hospital, a patient punched a nurse in the nose. The employer reported that the impact was minor and the supervisor downplayed it, calling it a brush against the nose, versus a punch. The nurse pressed charges and the patient threatened the nurse by saying to her and a medical resident, "If you show up at court, I don't know what my friends will do to you." The nurse feared for her life.
- A family member uttered threats to harm staff. The hospital went into lock-down. The person was arrested and will be released, at which time nurse safety

will again be at risk. The employer has security guards but does not have a proper means for nurses to summon immediate assistance when violence occurs, such as personal panic alarms with a wireless networking system and with real time locating capability.

## HOW CAN WE STOP VIOLENCE AGAINST OUR MEMBERS?

Make the employer comply with its obligations under the *OHSA* and the *Health Care and Residential Facilities Regulation (HCR)*. Nurses and all health care workers can no longer accept being unprotected victims of violence (both physical and verbal) in their workplaces. They must reject the notion that violence is an inherent part of the job.

So many members are subject to different forms of violence every day, up to and including murder. The sad story of ONA member Lori Dupont underscores the urgency for employers to address all forms and sources of violence in all of our workplaces. The Dupont Coroner's inquest laid out several recommendations that should be implemented to achieve an environment free from violence (for a copy, log on to the ONA's website at [www.ona.org](http://www.ona.org))

Clear from the Dupont inquest evidence, and as the MLITSD says on its website, "There is a continuum of unwanted behaviours that can occur in a workplace. This can range from offensive remarks to violence. It is important for employers to address any unwanted behaviours early to minimize the potential for workplace harassment to lead to workplace violence."

<https://www.ontario.ca/page/understand-law-workplace-violence-and-harassment>

The September 2016 amendments enhanced the harassment provisions of the *OHSA* by requiring the employer to ensure incidents and reports of harassment are investigated, and empowering inspectors to order third-party employer-paid investigations when the employer fails. Workers may be more inclined to report harassment hazards when they understand that employers will now have to do something, and by reporting harassment they may "nip harassment in the bud" and stop it from escalating along a predictable continuum to violence.

## Report Hazards

Health-care workers (HCWs) have a duty under the *OHSA* (Section 28) to report hazards to their employers or supervisors. It is clear that workers must report incidents and threats of harassment and violence to their supervisor.

With the September 2016 amendments, the employer must now have measures and procedures in place to report harassment to another person if the alleged harasser is the employer or supervisor. Most employers require workers to complete incident forms, yet many workers do not complete them either because they are too busy/short-staffed or are tired of their supervisor's/employer's disregard and inaction for worker safety.

There are times when workplace harassment will crossover to workplace violence. Employers may attempt to discourage reporting violent incidents – that began as workplace harassment – as workplace violence. The reason is that the violence sections of the *OHSA* require employers to implement a number of measures and procedures to protect the health and safety of workers and the workplace harassment sections of *OHSA* do not. In addition, when a violent incident occurs it must be reported to the JHSC within four days under the *OHSA* and must contain all the prescribed information in the applicable regulation.

As a result, the employer is not able to keep the matter confidential. In these cases we encourage workers to complete the violent incident forms to hold the employer accountable to address workplace violence and also recommend filing a grievance for an unsafe workplace.

The only way to truly get these resistant health-care employers to comply with their obligations under the *OHSA* is to hold them accountable and to do so in writing regardless of the severity of the injury or illness. (See new Appendix H – Form to Report a Health and Safety Hazard). A near miss or minor injury can only be prevented next time if it is reported and the supervisor and employer are held accountable. In addition, HCWs should advise the JHSC or HSR and the Bargaining Unit President/Labour Relations Officer of all workplace harassment and violent incidents so they can follow up. If the risk of violence is imminent, the Bargaining Unit President should consider calling the police and escalating the concern as quickly as necessary, with the employer, the union and the MLITSD, to protect a worker.

- As an example, in a psychiatric hospital a forensic patient went AWOL and was caught by police at the Quebec border and brought to another hospital, where he was being held until he could be transferred back to the first hospital. Rather than provide adequate security and a safe transfer vehicle, the employer decided to send a nurse and a psychiatric assistant to get in their van, pick him up and transfer him back. The ONA Bargaining Unit President teamed up with the OPSEU Bargaining Unit President as soon as they were made aware of the situation and together escalated safety concerns up to the executive office, emphasizing along the way to each supervisor their personal responsibility to take all reasonable precautions and their personal liability should something go wrong. ONA's Bargaining Unit President told the employer that she will have no choice but to contact the MLITSD if the hospital proceeded. She also educated her members involved about what the *OHSA* says about their right to refuse unsafe work. Thanks to their quick action, the employer altered its plans and put in proper safety precautions. (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form for Reporting an Unresolved Concern to Supervisor and Resources in Appendix J).

## Report Injuries/Illnesses/Incidents

- When a worker is injured or made ill because of any form of workplace harassment or violence related to the workplace, the worker should seek immediate medical attention with their physician regardless of the severity of the injury/illness
- The *Occupational Health and Safety Act* also requires the employer to notify the JHSC/HSR, the union and the MLITSD (as required) in accordance with the notice provisions of the *OHSA* (immediately if it's a fatality or critical injury and within four days for disabling injuries and illnesses). (*OHSA* Sections 51-53.) The notification requirements under the *OHSA* are different from the *Workplace Safety and Insurance Act (WSIA)*. The *OHSA* requires notification if work-related violence makes a worker disabled from performing their usual work or requires medical attention or worse.

Use the JHSC or HSR and collective bargaining and/or collective agreement and the *OHSA* to:

- Demand the employer develop/revise and implement a workplace policy and program for the prevention of violence; conduct facility-wide risk assessments

and reassess risk as often as necessary; develop and put into effect measures and procedures and training to prevent workplace violence; and deal with the effects of it. The policy should have a clear statement that violent behaviour of any kind will not be tolerated.

- Negotiate collective agreement language (locally or centrally as appropriate) that makes workplace violence unacceptable. At the very minimum, the collective agreement should set out the employer's responsibilities under the *OHSA* to:
  - Provide a safe and healthy workplace.
  - Ensure the employer develops, in consultation with the JHSC or HSR, a policy; conducts facility-wide risk assessments and reassessments; electronic, verbal and visual risk identification, communication/alert and tracking systems, properly trained security who can de-escalate, immobilize and detain/restrain, appropriate personal panic alarms, linked to security with wireless/GPS type real-time locating capability, and develops and puts into effect measures, procedures and training (including de-escalation and self-protection/self-defense) for the protection of workers from all forms and sources of violence, including domestic violence in the workplace.
  - Notify the union and JHSC or HSR if a disabling violent incident takes place.

Negotiate collective agreement language (locally or centrally as appropriate) that enhances minimum legal requirements, for example:

- Empower the JHSC to investigate all incidents of violence and harassment, not just critical or fatal injuries.
- Replace a worker's personal belongings if they are damaged during a violent workplace incident.
- Ensure initial (orientation) and ongoing education and training of all staff, including doctors, security and management.
- Ensure any member who ever has "authority over a worker" or "charge of a workplace" receives full supervisor competency training.
- Ensure that hazards of harassment and violence are brought to the attention of the JHSC or HSR as they occur and during regular JHSC or HSR workplace inspections.
- Ensure the employer has personal panic alarms for all workers at risk linked to security with wireless/GPS type real-time locating capability.

- Ensure the employer has an electronic, verbal and visual system set up consistently across the organization to flag persons (and their triggers) with a history of violent behaviour. Also known as a risk identification, communication/alert (electronic, verbal, visual), tracking system.
- Ensure an adequate number and level of trained security guards who can be “hands-on.”

Demand the employer commit to providing a safe environment.

- The OHSA requires employers, under Section 25 (2) (h), to take every precaution reasonable in the circumstances for the protection of a worker. The 2010 amendments place specific requirements on employers with regard to the prevention of violence and the management of harassment. If the OHSA has not been complied with, an inspector may write an order and/or the inspector or anyone with sufficient evidence may lay charges. Remember, the *Regulation for Health Care and Residential Facilities* places additional obligations on health care employers and requires them to develop, establish and put into effect, in consultation with the JHSC or HSR, written measures, procedures and training for the health and safety of workers. Depending on the results of the risk assessments, the measures, procedures and training may address, but not be limited to issues such as:
  - Safe patient/staff ratios.
  - Summoning immediate assistance when workplace violence occurs or is likely to occur.
  - Chain of command reporting/investigation and response.
  - Hazard/risk identification and implementation of controls.
  - Identifying the signs of violence.
  - Procedures that will alert staff to any person (and their behaviours, triggers, specialized care plans and worker safety plans) with a history of violent behaviour who they may encounter in the course of their work, including a police transfer of custody protocol or memorandum of understanding
  - De-escalation, self-protection/self-defence and physical intervention techniques.
  - Staff scheduling.
  - Whether work areas, such as parking lots, exits and workstations, are regularly inspected.
  - Situations where a worker could be trapped alone.

- Surge protocols.
- Restraints procedures that include process to protect workers.

(See Appendix A – Workplace Violence Prevention Policy/Program Checklist; Appendix B – Employers' Minimum Requirements Checklist; and Appendix C – Checklist of Some Specific Controls/Measures to Consider.)

- Ensure adequate support systems are in place for the abused victim. All too often, health-care workers fail to report incidents of harassment or assault because of the belief that being harassed or assaulted represents failure. We have also been conditioned to believe we must accept violent outbursts because it is part of the job, and therefore we excuse the patient. Caregivers will often downplay an incident because we believe we must be strong, in control and not show any weakness. We must attempt to dispel these attitudes. We must insist on appropriate counselling and support systems, legal assistance (should the health care worker choose to prosecute), sick leave where needed and advice about WSIB matters.
- Provide training to members on Professional Responsibility Complaints (PRCs) and file them where warranted. Simultaneously submit a copy of the workload complaint form to the supervisor as a health and safety concern when worker health and safety is affected by staffing. In addition to the normal parties who receive a copy of your workload complaint form provide a copy of your workload complaint form to your JHSC member or HSR. Unresolved workload concerns about worker health and safety should be provided to and reviewed by the JHSC or HSR.
- Ensure you speak to your Bargaining Unit President/LRO and your JHSC member or HSR when your employer is not taking every precaution reasonable in the circumstances for the protection of a worker. Consider filing a grievance if your collective agreement has language requiring the employer to train workers and/or has general health and safety language or language specific to harassment/violence that may protect workers.

## PREVENTION OF WORKPLACE VIOLENCE

Focusing on prevention is the best strategy for dealing with the problem of violence in the workplace. Prevention includes training and education. Above all, there must be a demonstrated organizational commitment to establish and actually put into effect policies, measures, procedures (a program) training and education that provide optimum protection to nurses and other health care workers. In our experience, few health care employers are being proactive and truly trying to proactively prevent workplace violence. Most spend their time and resources on reacting to workplace violent situations after a serious injury or after the MLITSD has been called.

ONA participated with Michael Garron Hospital in developing a best practice violence prevention program. That successful, leading-edge collaboration is described in a paper in *Healthcare Quarterly* by Bujna, E., Casselman, N., Devitt, R., Loverock, F., & Wardrope, S. (2015).

As a starting point, the employer must conduct a facility-wide risk assessment that provides a basis for program development or program revisions. Measures and procedures must be developed and put in place to address/control the risks identified in the risk assessment. These measures and procedures must be part of the workplace violence prevention program. The results of the risk assessments must be shared with the JHSC or HSR and if the assessment is in writing, a copy must be shared with the JHSC or HSR.

Health-care employers for the most part have been very slow to develop comprehensive and effective violence prevention policies, programs and training. Where they do exist, often we hear they have been developed without consulting the JHSC or HSR even though the HCR which applies to all hospitals and Long-Term Care Home employers is very clear that all measures, procedures, training and education for the safety of workers must be developed in consultation with the JHSC or HSR.

We also hear that many of these procedures offer little in the way of meaningful protections for workers and where they do, they are not actually being reinforced or enforced by the supervisors and the employer. We also hear that employers seldom do real training and education on all existing, new or revised measures and procedures, something that employers covered by the HCR are required to provide.



Providing core curriculum online training once a year is usually not sufficient content to meet the employer's requirements under the *HCR* to train and educate workers on all measures and procedures that are relevant to a workers' work (*HCR* Section 9 (4)). Many employers try to supplement core curriculum "training" by asking workers to read new policies, for example, and sign off that they read and understand them.

Workers too busy to read, comprehend or question them often sign off so they can go back and care for their patients/residents/clients. If your employer engages in any of this type of training in your workplace, speak to your supervisor and request proper training, and advise your JHSC or HSR, Bargaining Unit President/LRO that you have concerns about the "training."

The JHSC is a monitoring and advisory committee (the eyes and ears of safety for the workplace) that can make the workplace safer from harassment and violence by discussing health and safety hazards and concerns and making written recommendations at JHSC meetings. ONA has put together a next steps process, a sample written recommendation and additional recommendations to consider (see Appendix D, E & F) that any JHSC in any sector can follow and tailor to advance the issue of violence prevention at your next JHSC meeting. If the committee as a whole fails to reach consensus on a recommendation after good faith attempts, the worker co-chair can independently send a written recommendation to the employer.

For workplaces with six to 19 workers, the HSR should advance the recommendations by raising it with the employer directly.

The sample recommendation is only a starting point and should be tailored to include recommendations for control measures and procedures to eliminate the risks identified in the risk assessments, or that have been brought to your attention by any other means (e.g. workplace inspections, accident/illness reports).

## DEVELOPING A VIOLENCE POLICY/PROGRAM

The *OHSA* sets out a minimum standard of measures and procedures that all employers must develop as part of their violence program (see Appendix B). However, to determine how comprehensive your program should be depends on the results of the facility-wide risk assessment and the measures and procedures the employers must develop to control the risks identified in the assessment.

Therefore, a comprehensive violence policy/program requires considerable planning. An effective violence policy/program begins with senior management's commitment. Your employer, in consultation with the JHSC or HSR, should establish a multidisciplinary sub-committee to oversee the program development. This sub-committee should report to the JHSC and include management, union/JHSC worker members or HSR and point-of-care staff, security etc.

An effective and comprehensive program developed in consultation with the JHSC or HSR will also contain measures, procedures, training, and education built upon the findings of the facility- wide risk assessment and any subsequent reassessments of risk that are done. The following information along with the ONA checklist (see Appendix A) should help you assess measures and procedures your employer has or has not taken to develop a comprehensive and effective violence prevention policy/program.

### Develop a Policy

A workplace violence prevention policy should be developed in consultation with the JHSC or HSR. The purpose of this policy is to clearly articulate management's commitment to preventing workplace violence and to provide all employees with an overview of the employer's workplace violence prevention program. Elements of a policy should include but not be limited to:

- Showing an employer's commitment to protecting workers from workplace violence.
- A definition of workplace violence.
- Address violence from all possible sources.
- Roles and responsibilities of all workplace parties.
- Emergency response measures (including how to summon immediate assistance).

- Reporting.
- Investigation.
- Being dated and signed by the highest level of management (See Appendix G – Sample Workplace Violence Prevention Policy).

## **Developing/Revising a Violence Prevention Program**

### **Violence Risk Assessments**

In keeping with the requirement in the OHSA, an assessment of the potential for violence in your workplace should be undertaken to prevent workplace violence. A risk assessment is a systematic examination of all aspects of the work, to consider what can cause injury or harm, whether or not the hazards can be eliminated and, if not, how to control the risks. The first step in developing a violence policy/program is to determine whether a problem exists and, if so, to evaluate the size and scope of the problem. Your employer and JHSC or HSR should work together to conduct a violence risk assessment of your entire workplace. A copy of a risk assessment tool entitled “Workplace Violence Risk Assessment Tool” is available on the Public Services Health and Safety Association website at: <https://workplace-violence.ca/tools/workplace-violence-risk-assessment-wvrat/>

### **Survey**

A good way to determine the scope and consequences of a problem is to begin with a survey of the staff through a questionnaire. The survey should be developed and implemented in consultation with the JHSC or HSR. The Bargaining Unit can assist the employer by encouraging full participation, explaining the survey’s purpose, use of results, confidentiality, etc. at a union meeting.

### **Additional Violence Risk Assessment Steps**

In addition to the survey, the assessment should:

1. Review the history of violent behaviour in your workplace:
  - Review any incidents of violence by consulting existing incident/accident reports, first aid records, health and safety committee records, security logs, emergency response reports (e.g. code whites), unusual occurrence reports, grievances (violence, harassment, discrimination) and member anecdotes.

- Determine when/where incidents occurred to detect trends and patterns (e.g. location, time, patient/resident/client behaviours/acuity/population, level of staff, skills/training).
- Determine whether your workplace has any of the risk factors associated with violence, such as:
  - The requirement to work alone: Our community nurses and other members conduct unaccompanied visits to patients/residents/clients in their homes. Several of our small rural and northern community hospitals report that overnight emergency wards are staffed with one nurse, and police back-up may be miles away.
  - Staffing shortages: For example, one useful case involving a work refusal by St. Thomas Psychiatric Hospital nurses confirmed that staffing levels were unsafe and the MLTSD issued an order for increased staffing. (Decision No. 01/93-A.) Some inspectors in 2016 have been looking at staffing levels in high-risk areas.
  - Psychiatric, geriatric, drug/alcohol-affected and emergency patients or patients with a history of violent behaviour.
  - Dementia/behaviour units in long-term care homes.
  - Waiting areas that are crowded with patients waiting long periods for service.
  - Lack of, inadequate and/or poorly trained security, and unrestricted movement of the public.
  - Poorly lit areas, e.g. corridors, rooms, parking lots, etc.
- Conduct a visual inspection of your workplace and the work being carried out. Focus on the workplace design and layout and your administrative and work practices.

## 2. Evaluate the history of violent behaviour in similar places of employment:

- Obtain information from umbrella organizations with which you are associated, e.g. your industry Safe Work Association, the Public Services Health and Safety Association (PSHSA), WSIB, MLTSD, or union office.
- Seek advice from local police security experts.
- Review relevant publications. (e.g. Dupont Inquest and Casa Verde Inquest recommendations for advice applicable to your facility. Both can be found by logging on to ONA website at [www.ona.org](http://www.ona.org))

- Collect newspaper or magazine clippings related to violence in your industry.

Determine if there is a procedure to perform a proper initial and ongoing patient/resident/client assessment to identify clues/triggers of probable violence, including:

- Diagnosis, e.g. paranoid character, anti-social personality, etc.
  - Behavioural clues, e.g. posture: if a patient/resident/client is sitting tensely on the edge of a chair or gripping arm rests. Remember that increased tension often precedes violent behaviour.
  - Speech: the louder the patient/resident/client's voice, the greater the potential for violence.
  - Motor activity: An inability to sit still can be an indicator of violence.
  - Past history is an important clue predicting violence.
  - Impact of changes in the environment.
3. Obtain and review the specific legislation, guidelines and policies that apply to workplace violence prevention in your workplace, e.g. OHS Act and Regulations, OHRC, College of Nurses of Ontario (CNO) references, collective agreement, employer policies, etc.
  4. Organize and review the information you have collected. Look for trends and identify the occupations and locations that you believe are most at risk. Record the results of your assessment. Use this information at the JHSC meeting by making specific written recommendations to your employer to develop a prevention program for reducing the risk of violence pertaining to your workplace (HSRs should present the information and recommendations directly to the employer).

## **Develop, Establish and Put into Effect Controls/Measures and Procedures**

- A "Workplace Violence Prevention Policy/Program Checklist" is found in Appendix A – use it to assess your employer's progress in developing a Comprehensive Violence Prevention Policy/Program.

Measures and Procedures include but are not limited to:

- Summoning immediate assistance when workplace violence occurs or is likely to occur (e.g. a procedure on personal panic alarms, with a wireless/GPS type real time locating capability linked to security).
- Emergency/crisis response (Code White, Code Purple, Code Black).
- Reporting incidents of workplace violence to the employer or supervisor, including a process to bring unresolved complaints to the Board of Directors.
- Procedure to report to the police.
- Setting out how the employer will investigate and deal with incidents, threats or complaints of workplace violence (e.g., safety plan development, alarms, flagging, security), which may include outlining the steps taken toward incident follow-up and resolution including communication of incident resolution to appropriate workplace parties (i.e. complainant, union president, JHSC or HSR, Human Resources, occupational health and safety manager and co-workers).
- Establishing a crisis management/chain of command team and clearly outlining in a procedure each member's roles and responsibilities (who responds first, who are first complaints reported to, who is next in line to receive the complaint if that individual is not available or does not act upon the complaint).
- Employer reporting/notification obligations to the WSIB, MLITSD, JHSC or HSR, the union and in the *Long-Term Care Homes Act*, the Ministry of Health and Long-Term Care Compliance Inspector.
- Measures and procedures to deal with domestic violence (e.g., safety plan for victim or other workers at risk to ensure their protection. The safety plan may address issues like staff scheduling, work re-assignments, transfers, screening calls and ensuring information about victims' schedule/vacations/department transfer etc. are not revealed, and assistance for the worker to work with the police, courts, or other organizations that may already be involved).
- Employee support post-incident – debriefing, legal, protection.
- Methods of risk assessment to be used for specific areas or situations (for example, inspections, surveys, review of records, worker interviews, point of care risk assessments).
- Administrative work practice procedures (e.g., No-Access Policy).
- Flagging procedure/risk identification, communication/alert (electronic, verbal and visual) and tracking system that outline what electronic and visual system the employer has developed and consistently applies to alert all staff to patients/residents/clients/persons with a history of violent behaviour they may

encounter in the course of their work. The procedures should indicate when, how and where the patient's history and triggers are assessed and flagged.

- Developing a procedure that outlines how staff will be made aware of other persons with a history of violent behaviour they may encounter in the course of their work and what their responsibility might be to flag these persons.
- Appropriate procedure on the use of restraints, which include worker safety protections/equipment required to safely perform the procedure) and clarity on the differences between the MOHLTC and CNO.
- Security and crisis responses (e.g., lock-down drills).
- Surge protocols.

### **Some Specific Controls/Measures to Consider**

- A more detailed list of controls/measures can be found in Appendix C – “Checklist of Some specific Controls/Measures to Consider”. Use this checklist to assess your employer's progress in preventing workplace violence.

Specific violence prevention controls/measures include but are not limited to:

- Installing/providing communications systems (e.g. personal panic alarms, linked to security, with wireless/GPS type real time locating capability, panic buttons, voice-activated devices, radios, cell phones).
- Establishing emergency response teams and police liaisons.
- Addressing adequate and appropriate staffing.
- Having the appropriate staff member do the initial assessment.
- Ensuring appropriate patient/resident/client placement, that is, in the right facility and in the right unit within the facility.
- An electronic (e.g., alerts with behaviours, triggers, specialized care plans and worker safety plans that pop up on a computer when the name of a patient with a history of violent behaviour is entered) visual (wrist bands, signage on a patient door) and verbal flagging/risk identification, communication/alert and tracking system and the same for visitors linked to a patient/resident/client chart.
- Establishing effective communication strategies such as having an up-to-date care plan and effective end-of-shift reporting.
- Installing barriers or shields.

- Providing adequate indoor and outdoor lighting.
- Changing the physical layout of a building to increase visibility.
- Security (e.g. video surveillance – for more information on security, see page 31).
- Restricting building access, especially at night or on weekends.
- Badge system for patient/resident/client and visitors.
- Posting zero-tolerance signage throughout hospital/facility.
- Providing a visitor sign-in book to document who is entering and existing the facility.
- Installing curved or circular mirrors at hallway intersections.
- Furniture – Strategically place furniture, keep furniture to a minimum, ensure furniture is rounded with padded edges and/or if possible secure it to the floor.
- Workstations – Organize workstations and areas to minimize physical contact, use wide desks, tables or counters, raise height of counters, etc.
- Establishing a worker safe room in designated areas with telephone and/or security/alarm access to the outside and peephole.
- Waiting room enhancements – use calming paint colours, provide reading materials, television, reduce background noise, etc.
- Posting wait times at triage/registration and provide regular information about delays.
- Discouraging theft – Lock cupboards/storage areas, secure sharps storage, change entry system to the medication room and remove any internal deadbolts.
- Providing designated parking.
- Providing panic stations within parking garages and walkways.
- Grounds and parking lot design – Make sure entrances and exits are well marked, ensure parking areas and entrances are well lit at night, use security patrols and vary times for patrols, remove or trim tree branches and bushes, provide parking lot escort services after hours or when a risk has been identified, etc.



## Security and Emergency Response Controls/Measures

Your violence prevention recommendations may include some or all of the above and/or other suggestions deemed appropriate in your workplace. In addition to the controls/measures and procedures mentioned earlier, your JHSC or HSR may want to detail further security provisions in its recommendations, including:

- **Security Personnel:** It is often the case that security personnel have received little specific training to enable them to assist effectively in a violent situation or are restricted in their powers to subdue violent people. (ONA health and safety activists in one high-risk Thunder Bay facility worked with other staff to press for and achieve enhanced security presence with increased powers of restraint.) Trained security personnel can perform a valuable function in helping defuse violent situations and assisting when it is necessary with physical intervention and restraint of patients/residents/clients/persons who are acting out aggressively. For instance, Michael Garron Hospital has in-house security, and their security personnel are trained to the Canadian General Board Standard (CGSB) and perform all code white restraints with assistance from clinical staff. In some facilities, security guards monitor parking lots and escort agency staff to and from their cars in the evening and at night.

## Specific Training for Security Personnel

Michael Garron Hospital provides the following curriculum to train to its guards:

- Effective Communications.
- Crisis Management.
- Criminal Code Applications.
- Resistance Management (Use of Force Model).
- Handcuffing.
- Edged Weapon Defense.
- Baton Application.
- Report Writing.
- Every second year training for Court Appearance Preparation/Giving Evidence.

E-Learning in hospital includes:

- WHMIS.

- Emergency Procedures.
- Privacy.
- Michael Garron Hospital Safety Modules.
- Workplace Violence Prevention Program.
- Incident Reporting.

Additional training conducted in-hospital includes:

- Code Brown Training.
- Code Red/Fire Systems Training.
- Code Orange/CBRN Response Training.
- Emotional Intelligence.
- Diversity.
- Training for New Hire: Each new staff member in security is given seven days (12 hours) of on-the-job training and is provided a training manual that is signed off by the supervisors when each section is completed. This is done in addition to their regular training materials. Each new hire also participates in General Orientation (two days).

## International Association for Healthcare Security & Safety (IAHSS)

We have also heard from several security guards that the training material from IAHSS is very good and covers the principles of health care security and its application. Any guard in a health care environment would benefit from the theory provided in the IAHSS program.

- **Name Tags:** Name tags, with first and last names can be particularly problematic, especially in some settings. Nurses working in psychiatry have experienced harassment from patients/residents/clients who traced their telephone numbers and addresses because their last names were on their name tags. In such cases, nurses should simply display their first names only.
- **Emergency Codes:** Emergency codes can be helpful in both institutional and community settings. In institutions, "code white" should bring the aid of a qualified and trained emergency response team within a very short period of time. In the community, nurses can use emergency codes if they are in trouble in a client's home. They can alert staff at the office, while the client thinks they are just making a routine phone call. In some agencies, nurses are also told to

use the 911 emergency number if they get into a serious situation. In some institutions, nurses use a "code pink" if they are in a situation where they are being verbally harassed by a physician. When this code is called, nurses who are available come to the unit and surround the two individuals. They say nothing, but are "present" for the event. This has apparently been an effective mechanism in dissipating the physician's wrath and discouraging a continuance of the abusive behaviour.

- **Emergency Response Teams:** Is there anyone for the nurse to call when a patient/resident/client has become violent? Is there an emergency response team trained and prepared to deal effectively and safely with an aggressive patient/resident/client? Is security part of that team? Some agencies have such teams, which are summoned by pressing a personal panic button or calling a specific code, such as "code white name of unit" on the public address system. The individuals who comprise the team should have specific roles and responsibilities to carry out in such circumstances. The JHSC or HSR must monitor the effectiveness of any emergency response or on-call team and ensure its ongoing training and education.
- **Video Surveillance Cameras:** Video surveillance cameras, 24/7 live monitored in an area from a central location, can be useful.
- **Signal Sending Alarm Buttons that are Linked to Security:** These alarms will send a signal to security directly, which allows security to respond and locate the individual in distress quickly because of a wireless tracking mechanism.
- **Noise Making Alarms:** These alarms, which are body-borne or carried, are widely available. The assumption is that the loud noise they emit will act as a deterrent to a would-be attacker while summoning help from colleagues/passers-by. However, if the device is deep in a pocket or purse, there may be no time to locate and activate it before the assault takes place. In terms of design, they should be light, easy to operate and have one-time activation (not hold- down) buttons. If dropped or thrown, the alarm should continue. These noise making alarms should only be used as an interim measure until a personal panic alarm linked to security with a wireless/GPS type real time locating capability is implemented.
- **Two-Way Communication Devices:** Many systems are now available that allow two-way communication between a member of staff and a home base, such as portable telephones, cell phones and CB radios and the newer voice-activated devices. A few hospitals have recently purchased new voice-activated devices

for all workers to wear. They are used for daily activities like calling for the lab or for calling security. They also work in most areas of a facility, including stairwells.

- **“Panic Buttons”:** Strategically placed, "panic buttons" can be installed throughout an area where a threat exists. When these are activated, an audible or visual alarm is triggered on a monitoring console, specifying the precise location of the attack. A disadvantage with such systems is that unless buttons are numerous, a member of staff may not be able to activate one before an assault takes place.
  
- **Staffing Ratios:** Staffing arrangements are likely based on certain established criteria, which may not have considered the risks inherent in the job itself. It may be necessary for the JHSC or HSR to present written recommendations to the employer to increase staffing levels in dangerous situations. Where inadequate staffing levels are an immediate danger or where the JHSC's or HSR recommendations are not approved, the committee, union or any worker should consider calling the MLITSD. Keep in mind that the Ministry is reluctant to write orders for additional staffing however, as previously stated case law supports our position that the MLITSD can write orders for additional staffing. In Decision No. 01/93-A (*St. Thomas Psychiatric Hospital and Ontario (Ministry of Health) (Re)* (unreported, April 29, 1993, AP 01/93A Ont. Adj., D. Randall), the adjudicator supported the inspector's decision to order safe staffing levels. As mentioned, recently inspectors are probing patient/staffing ratios, but if the MLITSD won't write orders, speak to your Bargaining Unit President/LRO about other options which may include the possibility of appealing the non-issuance of an MLITSD order. You should also use the collective bargaining process to achieve continued safe staffing levels. Nurses who experience difficulty attaining adequate staffing on their units should also consider utilizing the Professional Responsibility Clause in the collective agreement that results in additional workload or practice concerns. JHSC or HSRs can use the Professional Responsibility Workload Report Forms when unsafe staffing levels are reported as evidence of unsafe working conditions for workers as well. It is also useful for the JHSC or HSR to question the employer on the steps to prevent a recurrence when they report on accidents or illnesses to see if the employer even considered or mentioned unsafe staffing levels that may have contributed to an injury/illness. Discuss these issues with your Bargaining Unit President/LRO.
  
- **Buddy System:** Many of our members work alone. Several of our small rural and northern community hospitals report that overnight emergency wards are staffed with one nurse, and police back-up may be miles away. Our community

nurses and other members conduct unaccompanied visits to clients in their homes. These circumstances place nurses and other health care workers at an increased risk of violence. Where there is a risk of violence, nurses should not work alone. Police officers don't. This is especially important when nurses are caring for individuals with a history of violent behaviour. In these situations, a buddy system should be established or other measures taken to ensure safety of the worker.

- **Police Liaison:** The police have an important role to play in preventing and containing potential violence in the community and on health care facility premises. The police should be consulted in the development of workplace violence procedures. In the community, nurses who are concerned about a particular visit are encouraged to take someone with them, such as an officer from the local police department or the Ontario Provincial Police. When police are called to a health care facility, there should be a clear understanding on both sides about how officers are to be deployed and which member of the health care team will assume overall charge of a situation.
- **Security Ideas from Other Jurisdictions/Employers:** A violence reporting program in the Portland, Oregon VA Medical Center identified patients with a history of violent behaviour in a computerized database. The program helped reduce the number of violent attacks 91.6 per cent by alerting staff to take additional safety measures when serving these patients. In a New York City hospital, identification badges and color-coded passes limit each visitor to a specific floor. The hospital also enforced the limit of two visitors at a time per patient. Over a period of 18 months, these actions reduced the number of reported violent crimes by 65 per cent. We are also aware that more hospitals have developed and put in place an electronic and comprehensive visual flagging procedure/system, which includes wrist bands, to alert staff to patients with a history of violent behaviour. (e.g. Michael Garron Hospital, Windsor Regional, London Health Sciences Centre, Southlake Regional Health Centre etc.)

## EVALUATION AND REVIEW

### How Often Should Reassessment Take Place?

The risks of workplace violence should be re-assessed as often as is necessary to protect workers from workplace violence. For example, a reassessment should be undertaken if:

- The workplace moves or the existing workplace is renovated or reconfigured.
- There are changes in the type of work (increased number and acuity of patients/residents/clients).
- There are significant changes in the conditions of work (a change to staffing levels).
- There is new information on the risks of workplace violence.
- A violent incident indicates a risk related to the nature of the workplace, type of work or conditions of work, and was not identified during an earlier assessment.
- When someone is injured or almost injured from workplace violence that indicates that current measures failed to “continue to protect workers,” therefore a risk reassessment is required.

The re-assessment/evaluation is necessary to ensure the workplace violence policy and related measures/procedures/program continue to protect workers from workplace violence. The employer is obligated under the *OHSA* to inform the JHSC, HSR or workers of the results of the re-assessment and if it is in writing, to provide the JHSC/HSR or workers with a copy of the assessment.

If you think a re-assessment is required, add it as an agenda item to your next JHSC meeting. If the employer side of the committee does not agree at the meeting that a reassessment is required, the worker co-chair can make a recommendation to do a reassessment. If that recommendation is not agreed to by the employer, you can consider your options including calling the MLITSD. You should talk to your Bargaining Unit President or Labour Relations Officer before calling the MLITSD.

## Public Sector Health and Safety Association Violence, Aggression and Responsive Behaviour (VARB) Tools

In 2015 the Ministry of Health and Long-Term Care and the Ministry of Labour convened a Workplace Violence Prevention in Healthcare Leadership Table. Its goal was to drive a positive shift in organizational workplace violence prevention efforts and to enhance the safety for health care professionals at work. The Leadership Table was made up of many stakeholders in the hospital sector – OHA, employers, health care unions, Public Services Health and Safety Association (the employer safety association for health care), MLITSD, and MOHLTC. ONA took a leadership role within the table.

In Phase I, there were four working groups (Leadership and Accountability, Hazard Prevention and Control, Communications and Knowledge Translation, Indicators, Evaluation and Reporting) who were given the task of making recommendations and creating tools and products to be used by employers, JHSCs and workers to achieve the leadership table's goal of workplace violence prevention. These working groups provided twenty three recommendations and thirteen products and tools which were endorsed by both Ministers and recommended by the Leadership Table which were incorporated into a final report released in 2017. One of the most successful recommendations was for the Minister of Labour/Health to promote the PSHSA's VARB tools.

The PSHSA tools that were promoted include:

### Workplace Violence Risk Assessment

The *Occupational Health and Safety Act (OHSA)* states that employers must assess and control risks of workplace violence. This needs to be done as often as necessary to ensure that organizational policies and programs continue to protect workers.

For these reasons each organization should have its own processes for determining how often to complete an assessment, and when to evaluate the effectiveness of the process as often as necessary. Generally speaking, revisions are needed when there is a change in the nature of the workplace, type of work, or conditions of work. Changes could include:

- layout or design
- increased or decreased staffing levels
- increased resident acuity

- increased resident population

The toolkit includes:

- Overview on the Four Steps of Workplace Violence Risk Assessment
- Risk Assessment scale and matrix
- An overview of three Enabling and Reinforcing Factors: JHSC Functioning, Safety Culture and Psychological Health and Safety
- Hazards, Controls and Solutions for Acute Care and Long-Term Care Facilities in # categories:
  - Hazard Category 1 – Physical environment risk assessment (completed for the organization as a whole including common areas)
  - Hazard Category 2 – Department/unit-specific work settings/practices (completed for each unit/department)
  - Hazard Category 3 – Direct care of potentially aggressive/responsive residents (completed in units/departments where client care is provided)

## Individual Client Risk Assessment

The Violence Assessment Tool (VAT) provides a snapshot of a client's immediate risk of violence by identifying behaviours associated with increased risk. With this insight, health care teams can efficiently assess the risk, apply control interventions if needed, and improve worker safety while helping to increase quality of care.

Following extensive stakeholder consultation, the VAT was adapted from the Brøset Violence Checklist and the Dynamic Appraisal of Situational Aggression instrument for use in multiple care settings.

The VAT contains two sections:

1. Behaviours observed and history of violent behaviour and a Risk Rating Scale to determine whether the client's risk level is low, moderate, high or imminently high.
2. Action items/Interventions.

The VAT is for use in acute care, long-term care, community care and emergency services (EMS).



The VAT should be completed at first contact with the client, and according to your organization's policies and procedures — e.g., in acute care this might be once every shift; in long-term care, it might be between prescribed Ministry documentation such as RAI-MDS or RAI-HC. Depending on the client's individual circumstances, further assessment may be required.

## **Flagging (Also Known as Risk Identification and Communication Systems, Alert Systems)**

Legislative changes in Ontario surrounding workplace violence have created new responsibilities and obligations for employers, and have given new rights to workers to refuse unsafe work. The changes have also broadened our awareness of the issue. Most importantly, they have strengthened our understanding that workplace violence is not acceptable. Under the *Occupational Health and Safety Act* (1990), employers and supervisors are required by law to take every precaution reasonable in the circumstances for the protection of a worker, including disclosure of information about a violent or potentially violent patient, to keep employees safe.

Employers, supervisors, staff — they all have a role to play in eliminating violence at work. Employers however have ultimate responsibility. They must also provide all workers at risk with information (including personal information) about a person with a history of violent behaviour. Workplaces, in turn, must adopt effective prevention strategies. One such strategy is a flagging-alert program to communicate violence-related risks to health care teams. By taking this kind of proactive approach to managing violent, aggressive and responsive behaviours, we can reduce the risk of harm to workers while providing patients with the best possible care. This handbook provides practical tools and information that will help organizations develop a sustainable flagging-alert program.

The handbook includes:

A flagging overview on the purpose, benefits and types of flagging, and related legal and ethical responsibilities.

1. The five key steps to developing a flagging program.

2. Two appendices:

Appendix A — Workplace Violence and Health Information Privacy Fact Sheet.

Appendix B — Sample Flagging Policy.

## Security

This toolkit is designed to help community and health care organizations, with or without designated security personnel, establish an effective security program. It aims to increase awareness and understanding of security program functions, program elements, and training requirements, many of which are based on best practices and industry-accepted standards. The toolkit provides sample tools to identify security program gaps and to develop a comprehensive and customized action plan.

The toolkit includes eight tools that can help you develop and implement an effective security program. These tools can be found in the following appendices:

- Security Program Self-assessment Checklist with Gap Analysis and Action Plan Appendix 1
- Sample Corporate Security Policy Template – Appendix 2
- Sample List of Security-Related Policies and Procedures – Appendix 3
- Workplace Security Fast Fact Awareness Tool – Appendix 4
- Sample Security Topics for Workers and Managers – Appendix 5
- Sample Security Guard Training Duration & Provider Considerations – Appendix 6
- Sample Security Guard Training Program Components – Appendix 7
- Sample Security Guard Training Checklist for Healthcare Institutions – Appendix 8

## Personal Safety Response System

The Public Services Health and Safety Association's Personal Safety Response System (PSRS) toolkit is designed to help community and health care organizations establish an effective PSRS that can effectively summon immediate assistance for impending workplace violence situations or an incident in progress. It aims to describe the PSRS; explain how the PSRS is a component of existing programs, processes and frameworks within an organization; and the need to consider PSRS as a system and not merely devices. The tool kit provides practical information regarding legislative requirements; key PSRS definitions; PSRS devices, procedures, training and implementation considerations.

All of the VARB tools above, leadership Table tools below and the 23 recommendations (not listed here) can be found at [www.workplace-violence.ca](http://www.workplace-violence.ca)

The following additional tools and products were developed in phase 1 of the Leadership Table:

## **Leadership and Accountability**

### **Accountability Framework**

The Sustainable Accountability Framework will be used as a guidance tool for hospitals to outline who is accountable for what in a hospital organization.

### **Transition Toolkit**

An online resource for hospitals which contains leading/good practices in six key areas.

### **Assessment Tool that Assists Hospitals in Identifying where they are in their WVP Journey**

The assessment tool is intended to assist hospitals in self-identifying where they are in their workplace violence prevention journey. This tool is not intended to identify risks or hazards, merely to accompany the transition toolkit in providing organizations a starting point to identify any key component that they could improve upon such as policies and programs, and incident investigation/reporting.

### **Workplace Violence Prevention Checklist**

Workers in health care facilities face significant risks of workplace violence. This health care checklist is designed as a prevention tool to enable health care and community care facilities to adopt leading practices when establishing systems and practices to prevent workplace violence.

## **Hazard Prevention and Control**

### **Pre-Risk Assessment Survey**

A set of questions to be asked prior to conducting a risk assessment.

**Terms of Reference for a Workplace Violence Prevention (WVP) Committee**

Sample document that outlines the terms of reference for a WVP Committee in a hospital.

**Triggers and Care Planning**

Resource to assist caregivers with identifying common patient triggers and mitigate risk of workplace violence through individualized care plans and other risk minimizing strategies.

**Engaging Patients and Families in WVP and Sample Brochure**

Resource to help patients and families understand their role in their care and ability to contribute to a safe and healthy work environment, and sample brochure for patients, family members and visitors.

**Training Matrix**

The training matrix is intended to be used as a guide to assist employers in ensuring that workers are trained to prevent and react to incidents of workplace violence, and internal policies and procedures, and roles and responsibilities based on their occupation and potential exposure to risk.

**Indicators, Evaluation, Reporting****A Set of Organizational and Provincial Indicators**

A recommended list of leading and lagging metrics to be used at the system and organizational level that can be used to measure improvement in workplace violence.

**Communication and Knowledge Translation****Communication Plan for Workplace Parties**

Resource to help stakeholders within the hospital setting to improve the knowledge translation practices and communication specific to workplace violence prevention.

## **Communication Plan for External Stakeholders**

Suggested communication/messages to stakeholders outside of the hospital setting.

## **Public Awareness Campaign**

Marketing brief with details on designing and conducting a workplace violence awareness campaign in the public.

In 2018 and 2019, Phase II of the Workplace Violence Prevention in Health Care Leadership Table worked on creating additional recommendations and developing tools specific to the long-term care (LTC) and community sectors as well as hospitals. Similar to Phase I, ONA was a leader in Phase II with ONA members representing the union on three Research and Development Working Groups comprised of a variety of stakeholders from each sector. There was one working group for long-term care, one for hospitals and one for community care. In Phase II it was ONA members who led the development and creation of tools that would assist employers, JHSC and workers in these sectors to prevent workplace violence. Although Premier Ford abruptly postponed the Leadership Table in this phase, the PSHSA published the tools from Phase II that were created for long-term care, community and hospitals. All phase II tools can also be found at [www.workplace-violence.ca](http://www.workplace-violence.ca)

The 18 recommendations developed jointly by labour and employer representatives of the Advisory Committee have not been addressed or approved by the Ford Government, which did not reconvene the Leadership Table.

## **Phase II Tools for All Sectors Include:**

### **1. Ensuring Supervisor Competency on Health and Safety for Managers and Supervisors**

This tool provides a framework for health-care organizations (hospitals, LTC homes and home care) to assess and supplement their current supervisor training where appropriate to ensure supervisors are competent on health and safety and the specific hazard of workplace violence.

### **2. Violence Response toolkit**

The purpose of this toolkit is to provide guidance and resources to all workplace parties on how to respond to the risk of violence and actual violent incidents and

prevent future incidents. This toolkit is an excellent resource for both new and experienced JHSC representatives. It provides clear guidance on each party's obligations in responding to a violent incident. It is an invaluable resource.

### **3. Workplace Safety Plans toolkit**

This Safety Plan Toolkit will provide clear and concise information to help workplace parties in health-care sector organizations develop an individual safety plan using a template, table of control examples, legislation checklist, sample policy and quick reference guide.

## **Phase II Tools for LTC Include:**

### **1. Accountability Framework**

Identifies the external and internal support, policy, culture, roles and practices in workplace violence prevention Ontario's LTC homes should adopt.

### **2. Transition Toolkit**

A resource that contains tools and resources from the Leadership Table along with other endorsed tools to support: leadership and cultural transformation; incident management; policies, programs, measures and procedures; training; response team and physical environment in LTC.

### **3. Assessment Tool**

A tool that helps LTC homes work with their JHSCs to determine where they are in their workplace violence prevention journey and where they need to improve.

### **4. WVP checklist**

A resource that helps LTC homes develop standards of practice that go beyond complying with the OHSA. The checklist focuses on five key performance indicators: leadership support and worker participation; hazard identification and risk assessment; risk mitigation, hazard prevention and controls; education and training and performance reporting.

### **5. Pre-risk assessment survey**

A series of questions employers can ask staff to help understand employees' concerns and perceptions with respect to workplace violence in LTC.

## **6. Terms of Reference for WVP Committee**

A tool that helps LTC organizations develop or improve their own terms of reference document for their workplace violence prevention committee.

## **7. Training matrix**

A tool to help employers provide comprehensive training based on the risk of violence to workers, supervisors, physicians, members of the board of directors, and others in their LTC setting.

## **8. Engaging residents and families in workplace violence prevention**

A resource to help residents and families understand their role in their care and ability to contribute to a safe and healthy work environment.

## **9. Triggers and Care Planning**

A resource to help LTC home staff identify common resident triggers and develop an individualized care plan to mitigate risk of workplace violence.

## **10. Communication Plan for Workplace Parties**

Plan which identifies key audiences within the LTC home, key messages, communication goals and strategies for communicating to different audiences

## **11. Communication Plan for External Stakeholders**

Suggested communication/messages to stakeholders outside of the LTC home setting.

## **12. Public Awareness Campaign**

A resource that provides details on designing and conducting a workplace violence awareness campaign to the public (i.e. general public, family members, caregivers visiting and caring for family and friends in LTC homes).

## **13. A set of Organizational and Provincial indicators**

A recommendation to facilitate measurement of WVP through provincial data collection and reporting of indicators that are relevant to long-term care.

#### **14. Effective Workplace Safety Huddle Communication Tool**

This tool will address the fundamentals of communicating the risk of violence to all workers (clinical and non-clinical) in LTC during safety huddles to ensure they are included in and made aware of relevant information for violence prevention and protection.

### **Phase II Tools for Community Care Include:**

#### **1. WVP Toolkit for Home Care**

The toolkit will strengthen the internal responsibility system (IRS) within organizations and guide employers to develop a safe home visit protocol/program for the safety of all its workers.

#### **2. Preventing Workplace Violence associated with Working Alone or in Isolation: A Resource for Employers, Supervisors and Workers in Hospitals**

A resource to advance health and safety for employees who work alone. It contains a tool to identify the specific jobs or tasks that are at risk of workplace violence due to working alone or in isolation hazards, a sample working alone policy and a checklist to help employers keep those workers working alone or isolated safe on the job.

The PSHSA has recently developed additional tools included in the VARB toolkit, including:

#### **Emergency Responses (Code White)**

The purpose of this toolkit is to provide information and guidance for health-care employers, supervisors, workers and Joint Health and Safety Committees (JHSCs) or Health and Safety Representatives (HSRs) responsible or participating in the planning, development, implementation and evaluation of emergency control measures and procedures to effectively respond to violence in the workplace. The toolkit provides resources and information on effective practices that can be incorporated into an employer's existing policies, control measures and procedures, or used to create new ones where none exist.



## **Work Refusals**

The purpose of this toolkit is to provide information and guidance for employers, supervisors and JHSC or HSRs in the health-care sector to support their organizational response to work refusals for reasons of workplace violence. The toolkit is also a guide for workers in health care to understand their right to refuse unsafe work due to workplace violence as well as the process.

## **Transitions**

This toolkit provides information on sound practices for planning a course of action, gathering resources and collaborating with workplace parties and other care organizations to transition care recipients with a risk of violence. It provides guidance and information on the following:

- Care Transition Basics
- Roles and Responsibilities
- The Phases of Care Transition
- Training

The toolkit also contains two helpful appendices, including a care transition form and situational awareness fact sheet.

Currently, PSHSA is developing an additional VARB tool on Incident Reporting and Investigating.

## TRAINING/EDUCATION

### Duties to Provide Information, Instruction, Training and Education

Training and education ensure that all staff are aware of potential hazards and how to protect themselves and their co-workers through established policies, controls/measures and procedures including equipment and devices.

Under the *OHSA*, an employer must provide appropriate information and instruction to workers on the contents of the workplace violence policy and program [Section 32.0.5(2)].

In workplaces covered by the *Health Care and Residential Facilities Regulation*, the employer is legally required to consult with the JHSC or HSR when developing, establishing and providing training and educational programs in health and safety measures and procedures for workers that are relevant to the workers' work (i.e., hospitals, long-term care facilities).

So, for the majority of our members this means the employer cannot limit themselves to only providing information and instruction to implement the violence policy and program but must provide training and education on all of the measures and procedures contained in the program that are relevant to the workers' work.

### Other Related Duties to Provide Information, Instruction, Training and Education

Under the *OHSA*, an employer has a general duty to provide information, instruction and supervision to protect a worker [Section 25(2)(a)].

A supervisor has a duty to advise workers of any actual or potential occupational health and safety dangers of which the supervisor is aware [Section 27(2)(a)].

To protect workers, the employer must tailor the type and amount of information, instruction, training and education to the specific job and the associated risks of workplace violence.

An employer should identify what information, instruction, training and education is needed when a worker is hired. This should be done by taking into account hazards associated with each specific job as well as the measures and procedures that are in place.

### **When/How Often Should Information, Instruction, Training and Education Take Place?**

Initial and ongoing training and education about the violence policy and about controls/ measures and procedures contained in the program should be provided to all new and existing employees, including the chief executive officer, health administrator, supervisors, managers and physicians.

Visiting staff, such as physicians, should receive the same training as permanent staff. Training records must be maintained.

Workers in jobs with a higher risk of violence or with high-risk patients may require more frequent or intensive instruction, specialized training and education.

Similarly, the employer should identify what information, instruction, training and education is needed when a worker changes jobs.

Employers should also identify how often information, instruction, training and education should be repeated. This should be done:

- Annually.
- In large institutions and areas (including smaller hospitals, homes and community care) with high-risk patients/residents and clients as identified in violence risk assessments, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees.
- When there are significant changes to the risks encountered.
- When there are significant changes to the workplace violence policy or changes to any of the numerous measures and procedures contained in the program.
- When circumstances indicate additional instruction, training and education is needed such as when procedures are not implemented or applied consistently or workers do not know about them. In some cases, inadequate training and education may be a contributing factor to violence that disables a worker. As a result, training and education may be one control measure, and is never the only control measure, implemented as a result of a violent incident.

## Effective Training Techniques

Effective training techniques include:

- The use of small groups of trainees (10 to 20 persons) led by several trainers to facilitate discussion.
- Brief lectures, together with videos, slides or written material for support.
- The use of role playing, simulations and drills.

The health-care regulation requires that the employer consult with the JHSC when developing training on health and safety measures and procedures. In our experience, this does not happen as it should in most cases. It is essential that we assert our members' right to relevant and effective training when it comes to violence and harassment at work.

The best training ONA has seen provided in Ontario is the Centre for Addiction and Mental Health's (CAMH) three-day program called, "Trauma Informed De-escalation for Safety and Self-Protection (TIDES)." There are also good programs delivered by Safe Management Group, such as a three-day Crisis Intervention Training Program which includes restraint application. Stay Safe Inc. also provides a similar three-day training program. The JHSC or HSR should raise concerns about inadequate training and make written recommendations to the employer to improve the crisis intervention using a new provider if the provider they currently use is not teaching them the necessary skills to protect them in violent assaults.

What is absolutely essential for a good workplace violence prevention training program is that the employer and the JHSC review incident reports in advance of the training. This ensures that the training can be tailored to address the violence hazards that are present in the workplace. There also needs to be modules available regarding specific violent behaviours, which can be delivered to units if they are dealing with a patient exhibiting behaviours. The flexibility to provide additional relevant unit-specific modules is one of the things that sets TIDES apart from the rest of the workplace violence prevention training programs in Ontario.

## Minimum Workplace Violence Prevention Training

As a minimum, workers in all workplaces should:

- Know how to report hazards and any incidents of workplace violence to the employer or supervisor.

- Be aware of and understand the employer's workplace violence policy and program.
- Know how to summon immediate assistance.
- Know how the employer will investigate and deal with incidents, threats or complaints.
- Know, understand and be able to carry out the measures and procedures that are in place as part of the program to protect them from workplace violence.
- Know how to protect themselves when responding to a code white or when being assaulted.

Be able to carry out any other procedures that are part of the program.

## **Additional Topics Covered by Information, Instruction, Training and Education**

The training should also cover topics such as the following:

- Early recognition of escalating behavior, warning signs/triggers or situations that may lead to assaults.
- Ways of preventing, de-escalating and/or managing volatile situations (including self- defense, self-protection and break-free/blocking techniques, safe-take down to the floor etc.) and/or anger and aggressive/abusive behavior. As a minimum, this training should be provided as a:
  - Single in-classroom workshop for all low-risk employees (no Patient interaction) of four to five hours.
  - One to two days of training for all medium-risk employees (if providing patient care to any high-risk patients – two days)
  - Two to three days of training.

Refresher training should be incorporated in the alternate year with full training as above every other year. In-classroom restraint training should also be provided yearly for any staff having to attend code whites and who may be required to apply restraints. Additional training that security guards receive, such as use of force and other advanced physical intervention skills should also be provided to any nurse who is acting in the capacity of security in the absence of well-trained hands-on security guards.

- The definition of workplace violence and harassment under the *OHSA*.
- A broad definition of violence and definition of sources of violence.
- All workplace violence controls/measures and procedures found in the violence program, including those developed as a result of the facility wide risk assessment (e.g. emergency response and communication, code white, flagging procedure/system, surge protocols, working alone procedure, point-of-care risk assessment procedure, restraints and security procedures, record keeping, reporting, investigation, summoning assistance [e.g. personal panic alarms linked to security]).
- Awareness of violence and abusive relationships (domestic violence).
- Risk factors that cause or contribute to assaults.
- Hazard identification.
- Appropriate use of restraints (safe methods of restraint application that protects the worker, personal protective equipment), including using psychoactive medications as chemical restraints. These medications are considered chemical restraints when not used to treat illness, but to intentionally inhibit a particular behaviour or movement.
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences.
- How to deal with hostile persons other than patients/residents/clients, such as relatives and visitors.
- The location and operation of safety devices, such as alarm and/or voice-activated device systems, along with the required maintenance schedules and procedures.
- Ways to protect yourself and co-workers, including use of the buddy system.
- Policies and procedures for obtaining medical care, counselling, WSIB benefits and police reporting and or legal assistance after a violent episode or injury.

## **Supervisors, Managers, Physician Leaders and Security Personnel**

Training of employers and supervisors and physician leaders should be provided to identify signs of abuse. Training also needs to cover how to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic and all other forms and sources of violence and harassment, including sexual harassment.

There is a specific definition of “supervisor” in the *OHSA*. If a worker has “authority over a worker” or “charge of a workplace,” for any amount of time, they meet the *OHSA* definition of “supervisor.” When appointing a supervisor, the employer is required to appoint a “competent person,” which means a person who is not only qualified to organize the work, but also is familiar with the *OHSA* and *regulations* and knows about potential and actual dangers in the workplace. Such “supervisors” have legal duties including taking every precaution to protect workers. The MLITSD states in its poster, “Who is a Supervisor under the *OHSA*?” that our members such as nursing home nurses and hospital charge nurses may at times be considered “supervisors” for purposes of health and safety law and liability. As such, it is important to determine if those members ever act in a “supervisory” capacity, full-time or otherwise, and ensure that the employer, “train this nurse to the same competency level as any other supervisor.”

Supervisors and managers should ensure that:

- Employees are made aware of the existence of any potential or actual danger to the health and safety of a worker of which the supervisor is aware.
- They respond quickly to any hazard they become aware of and take every precaution reasonable in the circumstances for the protection of a worker.
- Employees are not placed in assignments that compromise safety.
- Employees are encouraged to report incidents/hazards.
- They and their employees are trained to behave compassionately towards co-workers when an incident occurs.
- They know how to reduce security hazards.
- They are familiar with all of the employer’s measures and procedures and ensure they are implemented and enforced consistently with their workers.
- Employees receive appropriate training on all of the measures and procedures that are relevant to their work. This includes training on de-escalation, self-protection/self-defence.

Supervisors and managers should be able to recognize a potentially hazardous situation and must make any necessary changes in the physical environment, patient/resident/client care treatment program, clinical policies and procedures (e.g. patient transfer) and staffing policy and procedures to reduce or eliminate the hazards.

Security personnel need specific training from the hospital, home or facility, including:

- The psychological components of handling aggressive and abusive clients.
- Types of disorders.
- Ways to handle aggression and defuse hostile situations
- Physical skills such as use of force, restraints, sharp-edged weapons, self-protection/self-defence and in-classroom training consistent with the Canadian General Standards Board (CGSB) Training etc.

For more specific security personnel training, see page 31.

Training for all workplace parties should also include identification and exploration of personal beliefs about violence in the workplace, with an emphasis on disengaging the notion that violent incidents are just part of the job and/or personal responsibility and failure in the job.

### **P.I.E.C.E.S. Program**

Staff in the long-term care sector who work with individuals with complex cognitive and mental health needs, including those with aggressive behaviour, should have access to P.I.E.C.E.S. training. P.I.E.C.E.S. (for Physical, Intellectual, Emotional, Capabilities, Environment, Social) is a best practice learning and development initiative which suggests that prevention of problems and early intervention is preferable. The P.I.E.C.E.S. approach increases the detection of risk and the identification of supports to address risk-management issues. (For more information visit [www.piecescanada.com](http://www.piecescanada.com).)

Long-term care sector registered nurses may also have access to Regional Psychogeriatric Teams and since 2012, Behavioural Supports Ontario programs as a resource, and should use them.

Education in dementia and person-centered care is an essential strategy to avert aggression or responsive behaviours. A helpful tool in selecting the appropriate education is the BETSI, (Behavioural Education and Training Supports Inventory) Tool, which was published by Behavioural Supports Ontario (BSO). It is a comprehensive decision-making framework and program inventory that will strengthen the capacity of planners to choose the most appropriate educational programs and effectively support the application of new knowledge into practice. For more information, visit <https://brainxchange.ca/BSOBETSI>



## Training Evaluation and Review

The content, methods and frequency of training should be reviewed and evaluated at least annually in consultation with the JHSC or HSR by the team or coordinator responsible for implementation. Program evaluation may involve interviewing supervisors and/or employees, testing and observing and/or reviewing reports of behavior of individuals in threatening situations and a review of the risk assessments, inspection reports and accident/illness reports. The employer may be required to review and revise measures and procedures more often if it is asked to do so by the JHSC or HSR, or if there is a change in circumstances that may affect the health and safety of a worker. **It is always a good idea for the JHSC to use inspections and incident reports to identify the hazards that the training needs to address. If the hazard isn't covered by the existing training program the inspections and or incident reports provide evidence that the hazard exists and needs to be addressed.**

## Disruptive Physician Program

In December 2007, the Dupont Coroner's Jury recommended as a priority that the government "Develop a process or mechanism for the early identification of and response to Disruptive Physician Behaviour, including timely and effective disciplinary actions."

In 2008, endorsed by both the College of Physicians and Surgeons of Ontario (CPSO) and the OHA, the *"Guidebook for Managing Disruptive Physician Behaviour"* was released. The guidebook was produced, "in response to the growing body of literature that raised concerns about the behaviour of health-care professionals, physicians in particular, and the impact of behaviour on patient outcomes." (CPSO & OHA, 2008, p. 2). The guidebook provides a variety of tools the user may adapt to their own workplace setting.

ONA also has a guide to assist its membership and staff through the multiple processes for dealing with disruptive physician behaviour. This guide includes a synopsis of law and policies applicable to disruptive physicians, as well as guidance and flow charts to help develop appropriate responses when evidence points to a disruptive physician. The guidebook can be found at:

[https://www.ona.org/wp-content/uploads/ona\\_managingdisruptivephysicianbehaviourguide\\_20170627.pdf](https://www.ona.org/wp-content/uploads/ona_managingdisruptivephysicianbehaviourguide_20170627.pdf)

## Internal Responsibility System

All of the foregoing preventative measures can be achieved by working through your facility's "Internal Responsibility System" (IRS), which is implicit in the *OHSA*. Employers, supervisors, the JHSC or HSR and workers/unions, can cooperate to report and identify hazards and establish a violence prevention policy/program and training in your workplace. (For a detailed explanation of the IRS, see ONA's *Occupational Health and Safety: A Guide for ONA Members*).

If your IRS does not produce the results needed, the union should elevate the issue as high as necessary with the employer, the government, and the union as fast as necessary to protect workers (see ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form for Reporting an Unresolved Safety Hazard and Resources in Appendix J). ONA members in Windsor, London, Toronto, Sault Ste. Marie, Muskoka, Sudbury and Newmarket achieved progress towards violence prevention after the Ministry.

Additionally, many of our members gain success with staffing issues by using ONA's Professional Responsibility Workload Report Form and process. When members identify concerns for the safety of their patients, often it is also a safety concern that can affect the member. In addition to the normal parties who receive a copy of your workload complaint form provide a copy of your workload complaint form to your JHSC member or HSR. In these situations, ask your manager to also address the concerns as a health and safety hazard under the *OHSA*.

## DEALING WITH PATIENTS/RESIDENTS/CLIENTS

The health care worker's awareness of their inner feelings and responses to stress are important in properly managing violence. Staff should be encouraged to use these responses as cues leading to appropriate coping mechanisms, rather than as stimuli for panic.

Violence develops along a behavioral continuum, and it is important in dealing with patients/residents/clients to utilize appropriate responses to different levels of acting out.

### The Verbal Approach

Generally, the most effective treatment to verbal expressions of abuse is to talk to the patient/resident/client to try to get them to express their feelings verbally. However, any threats must be dealt with by firm, but supportive, limits with the willingness and ability to back them up. It is important to convey to the patient/resident/client that violence is not acceptable and that their lack of control will be dealt with by the staff's firm control.

### Food and Drink

If talking is not sufficient to defuse the situation, offering the patient/resident/client something to eat or drink may lessen their anxiety, if not contraindicated. It has been reported that a combination of talk and food will generally defuse the vast majority of potentially violent situations.

### Medication

If the offer of food and drink is not effective, the literature recommends medication be used to decrease the patient/resident/client's tension and anxiety, if ordered and the care plan sets out a protocol. It is asserted that effective management does not involve rendering the patient/resident/client helpless and physically inert. Rather, it helps them to modulate their own aggressiveness. Setting a physically safe distance between oneself and an agitated patient/resident/client can decrease both staff and patient/resident/client anxieties. If required, staff should call for assistance without hesitation.

Note: The use of Chemical Restraints must be in compliance with the *Long-Term Care Homes Act*, CNO Standards and the individual treatment plan.

## Security Personnel

If the administration of medication proves ineffective, a subsequent recommended strategy is to call in the security personnel/emergency response team using a specific code. Upon arrival, they should be situated so they can be seen by the patient/resident/client. Their presence will reassure the patient/resident/client that if they lose control, there are enough personnel to restrain and prevent them from harming oneself or others. In the event there is no security in the facility, there needs to be a means for calling a code and getting immediate assistance when violence occurs or is likely to occur, and where all staff responding are trained to the same level as well-trained hands-on security.

## Physical Restraint

If none of the above interventions is successful and the patient/resident/client's agitation reaches a point at which restraint is necessary (as a last resort), the security personnel/emergency response team can be asked to restrain or help restrain the patient/resident/client. Once the decision is made to restrain, it should be acted upon immediately.

The agency's policies and procedures regarding use of restraints must be observed. These policies must have been developed with reference to any relevant legislation, including the *Patient Restraints Minimization Act, 2001* and the *Long-Term Care Homes Act, 2007*. (CNO's Practice Standard: Restraints, (2009) is a useful reference.)

Physical restraints can be humane and effective. However, once the patient/resident/client is in restraints, the situation should be dealt with as an emergency and every effort must be made to get the patient/resident/client out of restraints, keeping in mind the College of Nurses of Ontario's (CNO) Practice Standard, *Restraints* (2009). This could involve rapid tranquilization and supportive therapy. "A least restraint policy does not mean that nurses are required to accept abuse." (CNO, 2009, p. 4.)

In an emergency situation, a nurse may physically restrain a patient/resident/client while attempting to contact a physician for an order to do so. The circumstances of the situation should be documented and it should be clearly indicated there was imminent danger to self and others if the patient/resident/client remained unrestrained. The continued use of restraints must be assessed by the nurse, the

physician and other members of the multi-disciplinary health care team on a regular and frequent basis. The goal should be for the temporary or short-term use of restraints.

Nurses have the right to use reasonable force to protect themselves and others from attack, but only the minimal amount of force necessary to control the violent patient/resident/client and, thereby, prevent injury. All incidents of abuse from patients/residents/clients must be reported to your employer and should be forwarded to your Bargaining Unit/LRO and to your JHSC or HSR. Reporting every incident of violence ensures the problem is known, which helps to reduce further incidents of violence. The importance of documenting staff actions in handling disturbed patients/residents/clients is emphasized. Critical incidents as described in the LTCHA would involve abuse to a resident and must be reported to the Ministry of Health and Long-Term Care.

### **The Ministry of Labour, Immigration, Training and Skills Development**

The *OHSA* is explicit in that violence and threats of violence by a person are real health and safety issues covered by the legislation. When you, your colleagues or your members are in imminent danger, call the police and/or the MLITSD. (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org))

If a worker refuses to work when threatened by violence, the MLITSD will be expected to respond in accordance with the *OHSA*. The limited right to refuse for certain workers described in the *OHSA* continues and because of your regulatory body, you must do so carefully (refer to ONA's *Right to Refuse Guide* at [www.ona.org](http://www.ona.org)).

## RIGHT TO REFUSE OR STOP UNSAFE WORK

Workers have the right to refuse work if they have reason to believe workplace violence, including a threat of physical force that could cause physical injury, is likely to endanger them (S. 43 (3) (b.1)). There is no right to refuse because of harassment.

The Act provides a conditional or limited “Right to Refuse” unsafe work for health care workers (Section 43 (2)). Health care workers who work in institutions can generally not refuse unsafe work when the life, health or safety of another person or the public is directly in danger.

This conditional “Right to Refuse” also applies to police officers, firefighters, ambulance workers and some other groups of workers who care for the public. The majority of Ontario workers do not have this condition put on their right to protect their own safety in the workplace. Even some health care workers, such as community health nurses who work outside institutions, have no statutory limitation put on their right to refuse unsafe work.

If a worker refuses to work when threatened by violence, the MLITSD will be expected to respond in accordance with the OHS Act. However, because of your regulatory body, an ONA member must do so carefully. (Refer to ONA’s “My Right to Refuse Unsafe Work: A Guide for ONA Members” at [www.ona.org](http://www.ona.org) )

Certainly no health care worker wants to jeopardize the life, health or safety of another person, but neither should they be expected by the employer to needlessly jeopardize their own safety. (See also ONA’s booklet, *Occupational Health and Safety: A Guide for ONA Members*. This can be downloaded from ONA’s website at [www.ona.org](http://www.ona.org) )

The Act also provides a conditional “Right to Stop Dangerous Work” for health care workers (Section 44-47). Designated JHSC members may initiate a work stoppage, but only in “dangerous circumstances” (Section 44(1)), which means a situation in which all of the following are true:

- The Act or the regulations are being contravened.
- The contravention poses a danger or a hazard to a worker.
- Delay in controlling the danger or hazard may seriously endanger a worker.

In most cases, it takes two certified members to direct an employer to stop dangerous work. One must be a certified member representing workers, the other a certified member representing the employer. In some special cases, a single certified member may have this right. Sections 45, 46 and 47 of the Act set out the procedure for exercising this right.

The same limitations apply to this right as to the “Right to Refuse.” That is, health care workers and others who work in a variety of health care facilities cannot initiate a work stoppage if doing so will endanger the life, health or safety of another person (Section 44(2)). This legal condition restricts the rights of health care workers to stop dangerous work, so if in doubt, members should consult their Bargaining Unit President/LRO or call the MLITSD.

## THE CRISIS IS OVER, NOW WHAT?

### **Situation 1: Physical Harm**

An ONA member has been physically attacked by a patient/resident/client or a member of the public and has sustained a physical injury. What do you do?

### **Situation 2: Verbal Abuse/Violence**

A member has been verbally abused by a surgeon in an operating room. In the past two months, they have repeatedly criticized their performance in front of colleagues and yesterday raised their voice to them and threw an instrument across the room. What do you do?



## I AM THE VICTIM – WHAT DO I DO?

### Seek Medical Treatment

**Situation 1:** Seek medical treatment. If you go to the emergency room or occupational health service, follow up later with your family doctor and/or with personal counselling (See Seek Post- Assault Counselling on page 53).

**Situation 2:** Consider medical treatment. There can also be psychological consequences of verbal abuse, which can require medical treatment. These can range from short-term psychological trauma to post-traumatic stress disorder. Depending on the nature and frequency of abuse/violence, employees may experience the following short and long-term reactions to abuse/violence by a patient/resident/client or someone else: anger, anxiety, irritability, depression, shock, disbelief, apathy, self-blame, fear of returning to work and of other patients/residents/clients, feeling sorry for the assaulting patient/resident/client, disturbed sleep patterns, headaches and a change in relationship with co-workers.

Health care workers in general may not accept the assault as a work-related incident, but may view it as part of the job. An intriguing reaction of staff who have been assaulted is to downplay the severity of the aggression, particularly if no injury occurred. This philosophy excuses the patient or abuser and allows administrators to permit the abusive/violent behaviour to continue through their silence and inaction.

**Situations 1 and 2:** Employer policies may also reference medical treatment that may be available or procedures to follow to assist members in these situations. Always check to see if such a policy exists.

### Notify Your Employer

**Situation 1:** Report the incident immediately to your supervisor/employer. Your employer should ensure your immediate safety and invoke the employer's violence policy and procedures, investigate the incident and take appropriate steps to stop the violence from occurring again. If the injury was critical (as defined under the *OHSA Regulation 420*) the employer must immediately notify a MLITSD Inspector, the JHSC or HSR and the trade union and must provide a written report containing the prescribed information to the MLITSD within 48 hours. (The prescribed

information for all notices of fatalities, critical injuries, accidents, injuries and illnesses for most health care workplaces can be found in Regulation 420 under the Act. If the worker is disabled from performing their usual work or requires medical attention but no person dies or is critically injured, the employer must still report the injury and all of the prescribed information to the MLITSD, JHSC or HSR and the trade union in writing within four days. If the worker or someone on behalf of the worker advised the employer of an occupational illness or made a WSIB claim, the employer must still report the illness and all of the prescribed information to the MLITSD, JHSC or HSR and the trade union in writing within four days. The employer and/or the worker may also contact the police, depending on the nature of the assault. The employer must also report this incident to the WSIB if the worker required health care treatment as a result of a physical or psychological injury and/or loses time from regular work, 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.

WSIB policy states they must receive an employer's complete accident report within seven **business** days of the employer learning of the reporting obligation. (Business days are Monday to Friday, and do not include statutory holidays.) Section 21 of the *Workplace Safety and Insurance Act (WSIA)*, however, states "an employer shall notify the Board within three days after learning of an accident...or if the accident necessitates health care or results in the worker not being able to earn full wages."

Workers must receive a copy of the accident report called a WSIB Employer Form 7 that is provided to WSIB (including any additional information provided by the employer).

**Situation 2:** Report the incident immediately to your supervisor/employer and also to your union/ and JHSC member as the employer is not obligated to share information about harassment incidents and complaints with the committee. Your employer should ensure your security, invoke the employer's violence and harassment policy and procedures, and must investigate your complaint and take appropriate actions to stop the abuse/harassment/violence. The employer must share the results of the investigation, and any corrective actions taken with you and your alleged harasser. Share a copy with your union and JHSC member as the employer is not required to provide one to the union JHSC.

If you suffered a psychological illness as a result of the harassment and advised the employer of this or made a WSIB claim, the employer must report the illness and all of the prescribed information to the MLITSD, the JHSC or HSR and the trade union in writing within four days. The employer must also report this incident to the WSIB

if the worker required health care treatment as a result of a psychological injury and/or loses time from regular work, 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.

## **Contact Your Union Representative and JHSC Member or HSR**

**Situation 1:** You should contact your Bargaining Unit President/LRO and JHSC member or HSR as soon as possible after the violent incident. The union and JHSC member or HSR can assist you in immediately responding to this incident. Where there is an employer policy/program or collective agreement language in place that deals with violence, your ONA representative and JHSC member or HSR should refer to the procedures in the policy/program and collective agreement to ensure the employer has responded accordingly.

You should also check the *OHS*A to ensure that your employer's policy and program is comprehensive and is consistent with their requirements to protect workers under the *OHS*A and the HCR (i.e. hospitals, long-term care homes). If appropriate, your representative or JHSC member or HSR may contact the MLITSD and/or the police, if the employer has not done so. Depending on the situation, the union representative may also direct you to ONA's Legal Expenses Assistance Program (LEAP) for advice in speaking with officials. A full investigation of the incident by the employer, the union, the JHSC or HSR, the MLITSD, the police, or any combination of these parties, should commence as soon as possible. If you have any bruises or other visible signs of injury, a colour picture should be taken that will help to show the extent of the injury.

**Situation 2:** Share your complaint and any reports from the employer with your union representative/JHSC member or HSR. They can ensure that the employer is fulfilling its responsibilities under the *OHS*A and collective agreement, and can assist you in getting the various means of support you need. They can help you to call the police.

## **File a WSIB Report and Complete an Incident Report for Situations 1 and 2:**

- If the violent incident (physical or verbal) causes any physical and/or psychological injury/illness (e.g. bruising, sprains/strains, post-traumatic stress disorder), you should ask your employer to complete a Form 7 (Employer's Report of Injury/Disease). This is the official WSIB employer reporting form and

the employer is required to give you a copy. Ensuring your accident is properly reported to WSIB may prevent others from being exposed to a similar incident/hazard. Your employer will be more likely to address this serious health and safety issue when all injuries/illnesses are properly reported to WSIB. For the claim to be officially registered, workers will also be required to complete and sign a WSIB Form 6, file it with WSIB and provide a copy of this form to their employer. A copy of the form can be found at [www.wsib.ca/en](http://www.wsib.ca/en)

- You should fully document your injury/traumatic incident on an employer's incident report and tell your JHSC or health and HSR and your union representative. An injury/incident can appear minor at first, but continuing problems may ensue or problems may only commence sometime after the event occurred (i.e. post-traumatic stress disorder). This documentation will also be important for the purposes of investigating the violence/abuse. Filing an incident report is another means of notifying the employer that violence in the workplace must be addressed. If all violent incidents (physical and verbal) are reported promptly and recorded on incident reports, the JHSC or HSR will be able to use this information to track problems and identify areas where changes need to be made.

## **File a Grievance**

**Situations 1 and 2:** Some collective agreements contain provisions pertaining to violence, training or more general language like requiring the employer to take every precaution reasonable in the circumstances for the protection of a worker. Where such provisions exist, consider filing a grievance if you believe the employer has failed to make reasonable provisions for your health and safety and/or if you feel you have been subject to harassment. You should speak to your grievance chair and/or Bargaining Unit President/LRO to determine whether this is a possibility.

## **Lay Charges against Patient/Resident/Client or Other Perpetrator (e.g. family member)**

**Situations 1 and 2:** Assault is a criminal offence. If the police do not lay charges, you can still have charges laid. You can go to a Justice of the Peace, give a sworn statement of the event and file a private criminal charge. Some employers are very supportive to a member in their decision to press charges. ONA has encountered more than one employer who sends someone with the member to lodge the complaint and provides taxi vouchers to get there and home afterwards.

In Canada, there are precedents for holding a patient/resident/client responsible for assault on a staff member. For example, St. Paul's Hospital in Vancouver instituted a charge of assault against a patient who attacked a nurse. The defense argued that dealing with violence and sustaining injuries were inherent in any job in psychiatry and that by accepting a position in a psychiatric setting, the employee had given permission to be assaulted. The argument was rejected by the judge, who concluded that the setting was irrelevant and held the patient accountable for their actions.

In 2003, the negligence provisions of the *Criminal Code of Canada* (CCC) were amended by the "Westray Bill," making it possible now to find employers and others responsible for criminally negligent acts that result in worker injuries and death. Police should be looking more closely at what employers and others have done to avoid preventable acts of violence by patients/residents/clients and others in workplaces. Instead of just focusing on the patient/resident/client or other person who commits the act, the police should consider charges against negligent employers, directors and executives who did not take measures to prevent violence from causing serious harm to a worker. If the police do not investigate and prosecute criminal acts – be it assault or corporate negligence – any individual with sufficient evidence to support a charge can swear an information (lay a charge) before a Justice of the Peace.

## Apply for Benefits from Victim Services Ontario

**Situation 1:** You may be entitled to Victim Services Ontario supports. Information can be found at: <https://www.ontario.ca/page/victim-services-ontario>

## Seek Post-Assault Counselling

**Situations 1 and 2:** Victims of violence need a variety of services and employee victims are no different. They require medical attention, counselling, legal advice and information regarding insurance, WSIB benefits and rights pertaining to health and safety in the workplace. They should receive medical and psychological care the same as any other person: confidential, objective and impartial care given away from the work unit.

In Ontario, some hospitals' policies state that counselling will be provided to staff who wish it. In fact, guidelines developed by the OHA for its member hospitals

recommend that hospitals "provide support and counselling to staff subjected to abusive behaviour from patients." An assistance program where **confidentiality is guaranteed** should be designed to help staff deal with the impact of institutional violence. The Centre for Addiction and Mental Health provides staff with Trauma Psychological Services, providing staff with six sessions of Cognitive Behaviour Therapy with a psychologist, which is above and beyond worker benefit coverage. They also have the COPE Line for immediate support, staffed by certified crisis counsellors (e.g. psychotherapists, social workers) who offer telephone, web chat or face-to-face counseling.

Community support groups, women's centres and workers' occupational health and safety clinics may also be useful resources to the employee victim of violence. (See Appendix J)

## I AM A UNION REPRESENTATIVE, (ONA REPRESENTATIVE, ONA JHSC MEMBER, ONA HEALTH AND SAFETY REPRESENTATIVE) AND AM NOTIFIED OF VIOLENCE TOWARD A MEMBER. WHAT DO I DO?

### Ensure the Member Receives Medical Treatment

**Situation 1 and 2:** (See "I am the Victim," above).

### Notify the Employer

**Situation 1:** Your employer should ensure the member's immediate safety, invoke the employer's violence policy and procedures, investigate the incident, take appropriate steps to stop the violence from occurring again and may contact the MLITSD to report a critical injury if appropriate. The employer may also contact the police, depending on the nature of the assault.

**Situations 1 and 2:** Often a nurse who has been assaulted (physically/verbally) by a patient/resident/client is required to continue to care for that patient/resident/client. This can be very stressful for the nurse. Therefore, you should stress the need for the nurse to have the option to be relieved of continuing to care for that patient/resident/client. This may be difficult in small facilities; the patient/resident/client may need to be transferred.

Our members report that many employers tend to blame the victim for provoking the patient/resident/client's violent/abusive behaviour. Do not allow the employer to dismiss this matter as a nursing care issue. Occupational violence from anyone is an occupational health and safety matter invoking all of the employer responsibilities outlined in the OHSA. (See ONA's *Occupational Health and Safety: A Guide for ONA Members* at [www.ona.org](http://www.ona.org), as well as responsibilities under the CCC.

Your employer should ensure the worker's security, invoke the employer's violence policy, investigate the worker's complaint, and take appropriate actions to stop the violence/abuse.

## **Call the Ministry of Labour, Immigration, Training and Skills Development and/or the Police and ensure JHSC/HSR involvement**

**Situation 1:** If your employer has not summoned the MLITSD and/or the police, depending on the nature of the injury, you can call the Ministry to report a fatality, critical injury and/or request an investigation. You can also call the police to investigate the assault. You should also call the MLITSD if your employer is not taking every precaution reasonable in the circumstances to protect you or your colleagues' safety from other possible assaults even when the assault did not result in a "fatality" or a "critical" injury."

Depending on the situation, you may also direct members to ONA's Legal Expense Assistance Plan (LEAP) for advice in speaking with officials.

Ensure a full investigation of the incident is commenced by the employer, the union, the JHSC or HSR, the MLITSD, and the police or any combination of these parties, as soon as possible. If the victim has any bruises or other visible signs of injury, ensure that a colour photograph is taken that will help show the extent of the injury.

The investigation should examine precipitating factors, analyze the event, identify any patterns/triggers of escalating violence and also identify any policies, controls/measures, procedures and training that were non-existent or deficient.

The JHSC or HSR investigation should focus on determining what happened with a view to recommending steps to prevent a recurrence. With information from the investigation the JHSC or HSR should develop written recommendations that address the hazard of violence and ensure they are forwarded to the employer. (HSRs can present recommendations directly to the employer under section 8 (10) of the *OHSA*, while recommendations from a JHSC should be sent by the JHSC co-chairs (after obtaining consensus) or by a single co-chair if good faith attempts to reach consensus failed. (See Appendix E & F.)

Under the *OHSA*, the employer must provide a written response to written recommendations from the HSR, JHSC or worker co-chair within 21 days. If the employer does not respond within this time period or if their response will not fully protect workers from violence, contact the MLITSD. (See Resources in Appendix J).

ONA has developed an investigation tool that may assist JHSCs or HSRs in conducting their investigations. A copy of ONA's "Critical Injury/Illness/Accident



Exposure Investigation” tool can be downloaded by logging on to ONA website at [www.ona.org](http://www.ona.org)

If the Ministry does not issue orders or prosecute, and/or the police do not prosecute, ONA may want to consider appealing the non-issuance or insufficient orders or launching its own prosecution under the *OHS*A or CCC and advise the worker that they can lay private criminal charges before a Justice of the Peace.

**Situation 2:** Depending on the nature of the verbal abuse, it may also be appropriate to involve the police and/or the MLITSD. Regardless, your employer should have a violence/harassment policy, controls/measures, procedures and training in place.

If they do not, the JHSC or HSR should write a recommendation as noted above, and if the employer response is not satisfactory, call the MLITSD and/or the police.

## **Ensure the Workplace Safety and Insurance Board Claim and Incident Report are Completed**

**Situation 1 and 2:** The member may be entitled to WSIB benefits. To prevent problems with the member’s claim, ensure all documentation is fully completed. The worker should complete a Form 6 and provide a copy to the employer (Completing an incident report is not a guarantee that your employer has sent a Form 7 to the WSIB reporting your accident or illness). For more information on reporting WSIB accidents and illnesses, download a copy of ONA’s *Workplace Safety and Insurance Board (WSIB): A Guide for ONA Members* by logging onto [www.ona.org](http://www.ona.org)

## **Involve the JHSC or HSR Situations 1 and 2:**

If you are not on the JHSC, notify your union member on the committee or HSR of the violence/abuse. If you are a member of the JHSC:

- Ensure the JHSC’s designated worker member (who is designated to investigate when a worker is killed or critically injured) is advised and commences an investigation as soon as possible if the member is killed or suffers a “critical injury.”
- Ensure your employer is providing you all accident/illness information containing all information as prescribed in Section 3 of the Regulation - *Notices And Reports Under Sections 51 To 53.1 of the Act – Fatalities, Critical Injuries,*

*Occupational Illnesses And Other Incidents.* All employers must provide this information within four days of an accident or illness.

- Ensure the incident is brought before the JHSC or to the HSR, even if the injury is not "critical," to press the employer to implement controls/measures and procedures to protect all staff from workplace violence.

The employer may assert that the physician abuse is "harassment" and not "violence." Even if the facts substantiate this assertion, the employer is required to investigate complaints of harassment. However, be aware your employer is only required to provide the results of the investigation and any corrective actions to the complainant and the alleged harasser. As such, the union and JHSC should make every effort to stay in close touch with the complainant to provide support throughout this closed process, as well as to access information that may be relevant not only to the victim's health and safety but also to the health and safety of other potentially affected workers.

The JHSC has the power under Section 9 (18) (a) of the *OHS*A to identify hazards, (HSR's powers fall under Section 8 (10)), therefore:

- Press the JHSC or HSR to recommend the employer provide to the committee or HSR all incident reports involving violence/abuse, whether or not there is an injury/illness
- Check your collective agreement. Some agreements contain a provision that obliges the employer to notify the union of a violent incident within a certain period of time.
- Press the JHSC or HSR to recommend the employer complies with the *OHS*A (s. 25 (2) (I) and 32.0.3 (3) (a) & 32.0.3 (5), and provide copies of all risk assessments or the results of any assessment if they are not in writing to the JHSC/HSR and copies of any other report (e.g. investigation reports).
- Advocate for the JHSC or HSR to analyze and investigate as needed, violence and harassment incidents/accidents for the purpose of making written recommendations to the employer to improve its harassment/violence policy, controls/measures and procedures (a program) and training and eliminate harassment/violence in the workplace.

- Request that a health and safety inspector from the MLITSD inspect the workplace and write orders/make recommendations to the employer to put controls/measures, procedures and training into place to prevent violence/abuse if the committee's investigations reveal the employer has failed to take reasonable precautions to protect the health and safety of the staff.
- Repeat the steps under "Call the MLITSD and/or Police" above if your employer refuses to recognize that a problem exists or fails to deal with the problem in a satisfactory manner.

## **File a Grievance**

**Situations 1 and 2:** Check your collective agreement for violations. Where applicable under the collective agreement, file a union grievance and advise the member to file an individual grievance if the employer has failed to make reasonable provisions for health and safety and/or harassment prevention.

## **Ensure Counselling**

**Situations 1 and 2:** Direct the member to counselling services that may be available (See "Seek Post-Assault Counselling," page 53).

## **Ensure Supportive and Respectful Treatment of Victim**

**Situations 1 and 2:** It is imperative that any nurse or other health care worker who is the victim of occupational violence be treated with the utmost respect and consideration by their supervisor, colleagues and other members of the health care team. Both peers and managers may fail to recognize that a nurse has been deeply affected by an assault/abuse, especially if their injury is psychological in nature or the nurse's physical injuries are minor.

An assault/abuse on an employee elicits a variety of reactions from colleagues. Some staff are supportive, while others blame the nurse. Nurses, as front-line workers, are more vulnerable and accustomed to these incidents. Therefore, while nurses may show a lot of concern for a fellow nurse who is assaulted, other professionals on the health care team may minimize the assault/abuse and show little concern.

One of the most common responses to a harassment or violent incident at work is to blame the victim. Co-workers may question or criticize the assaulted/abused worker's ability to deal with difficult patients/residents/clients or crisis situations.

Disapproval by peers promotes the suppression of typical feelings at a time when talking about the experience is therapeutically desirable and cathartic. Covering up and denying the situation demoralizes front-line workers and negatively affects patient/client/resident care. An essential part of any organization's policies and procedures in dealing with violence should include a program to assist the abused (assaulted).

## I AM A CO-WORKER AND HAVE WITNESSED/BEEN ADVISED OF VIOLENCE/HARASSMENT TOWARD MY COLLEAGUE. WHAT DO I DO?

**Situations 1 and 2:** If you are able, you should contact your Bargaining Unit President/LRO to ensure the steps recommended above are taken. You should also advise your supervisor and your JHSC member or HSR. In the meantime, ensure your colleague receives medical treatment and remember if you have witnessed violence/abuse against your co-worker, you too may be in need of medical treatment and/or counselling.

Be certain to seek proper attention for your own needs. If you believe you or your co-workers' health and safety may be at risk and your supervisor is not addressing your concerns, the union should elevate the issue as high as necessary as quickly as necessary to protect workers. The union can call the MLITSD and file a formal complaint. (See ONAs "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form to Report an Unresolved Safety Hazard and Resources in Appendix J).

## CONCLUSION

The recognition of workplace violence/harassment as an occupational health and safety issue compels us all to confront the potential and known hazards in each of our workplaces.

As a union, we must develop strategies to attack the problem. These strategies can generate action plans for implementation at a number of levels. Ensure you report any hazards of which you are aware to your supervisor and the union will escalate all unresolved concerns as high and quickly as necessary if your supervisor does not take immediate action to protect your safety (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form to Report an Unresolved Safety Hazard and Resources in Appendix J). Raise local problems and unresolved issues at the JHSC or with your HSR. Ensure the JHSC or worker co-chair (or HSR) sends written recommendations to the employer proposing risk assessments and the development of, or improvements to, the employer's violence/harassment policy and program controls/measures, procedures and training.

Secure improvements through the collective bargaining process and lobby for progressive changes to legislation and regulations. For all health and safety concerns, it is important you ensure the employer has taken every precaution reasonable in the circumstances for the protection of a worker.

It is also particularly important for our Locals to be involved in helping and supporting fellow members who are the victims of violence/abuse. This can make an important difference in recovery.

It is only through reporting all hazards to your supervisor/employer and working together and supporting each other as nurses that we will successfully defeat occupational violence/harassment.

## ACKNOWLEDGEMENTS

The Ontario Nurses' Association acknowledges and appreciates the expertise and resources the Public Services Health and Safety Association (PSHSA) provided to ONA to use/adapt in the development of this guide and its tools.

## APPENDIX A:

# Workplace Violence Prevention Policy/Program Checklist

### How to Use this Checklist

The *OHSA* requires employers to develop a workplace violence policy and program. The program is to include measures and procedures to control the risks that are identified in the risk assessment conducted of the entire workplace.

The *OHSA* Section 32.0.2 sets out a minimum requirement of the measures and procedures that an employer must include in the violence program regardless of the risk assessment. (For a checklist outlining an employer's minimum requirements see Appendix B). This comprehensive checklist has been designed to address other known hazards/risks that the JHSC or HSR may identify or that may be identified through the facility-wide risk assessment. It also contains examples of other measures and procedures that the employer should consider and that may be in effect at other ONA workplaces.

For all members covered by the *Health Care and Residential Facilities Regulation* (the health care regulation) (i.e., hospital and long-term care workers) the employer is also required under Section 8 of the health care regulation to consult with the JHSC or HSR when developing, establishing and putting into effect measures and procedures for the health and safety of workers. This means all measures and procedures for the prevention of violence are included in this requirement. Section 9 of the *Health Care and Residential Facilities Regulation* also requires the employer to reduce these measures and procedures to writing and to develop, establish and provide training and educational programs in consultation with the JHSC or HSR.

Complete this checklist to identify what key elements of a workplace violence policy/program your employer already has and what elements may still be required. Where deficiencies are identified, the JHSC or HSR should prepare a written recommendation(s) (see Appendix E and F) to the employer for the protection of workers. A single co-chair of the committee can also send recommendations to the employer when good faith attempts to reach consensus failed. (See Appendix E and F). The employer has 21 days to respond and if their response does not adequately resolve the hazard, call the Ministry of Labour, Immigration, Training and Skills Development. (See Resources in Appendix J). A word version of these tools can also be found by logging on to ONA website at [www.ona.org](http://www.ona.org)

## Workplace Violence Prevention Policy/Program Structure is in Place

1.Senior Management Commitment (demonstrated through assigned leader with dedicated resources).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
2.Multidisciplinary Committee – should be a sub-committee of the JHSC that includes management, union/JHSC worker members or HSR and point-of-care staff, security etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

## Workplace Violence Prevention Policy

1. A workplace violence prevention policy is developed and includes: <ul style="list-style-type: none"> <li>• Showing an employer's commitment to protecting workers from workplace violence.</li> <li>• A definition of workplace violence.</li> <li>• Address violence from all possible sources.</li> <li>• Roles and responsibilities of all workplace parties.</li> <li>• Emergency response measures (including summoning immediate assistance).</li> <li>• Reporting.</li> <li>• Investigation.</li> <li>• Addresses a system to identify persons with a history of violent behaviour.</li> <li>• A date and is signed by the highest level of management.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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## Workplace Violence Prevention Program Risk Assessment

### Risk Assessment

1.Evidence that a risk assessment has been conducted for the entire workplace and is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
2.A copy of the risk assessment is shared with the JHSC or HSR. If it is not in writing, the results are shared with the JHSC or HSR, multi-disciplinary team and the employer.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
3.The prevalence of violence in the nearby community has been ascertained – police communications.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
4.The history of violent behaviour in similar places of employment has been evaluated.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
5.Internal indicators have been analyzed (e.g. incidents/accidents, near misses, code white calls, security reports).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
6.An environmental assessment has been conducted (e.g. working alone or remote areas, areas with public waiting areas, etc.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

7. Workplace design and layout has been assessed (lighting, physical layout of workstation, location of closest and safest parking spot, etc.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
8. An action plan to control the risks identified has been developed and identifies a most responsible person with timeframes for completion.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
9. Point-of-care work practices assessment has been completed (e.g. staff reviews a patient/resident/client's profile before meeting with that client, etc.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
10. Employee survey has been conducted and analyzed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
11. Security guard deficiencies, shortages, training and response have been assessed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
12. Staff shortages have been assessed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

### Risk Assessment Follow-up and Evaluation

1. Were the recommendations made for corrective actions and improvements implemented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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2. Were all corrective actions and improvements assessed and evaluated?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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### Reassessment of Risk

1. A process has been developed to reassess the risks of workplace violence as often as necessary to ensure the violence policy and program continues to protect workers.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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2. A process has been developed to reassess risk whenever there is a surge in patient population, acuity, patient flow, staff absences that can create unsafe staff to patient ratios, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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3. Copies of all reassessments are shared with the JHSC or HSR and if they are not in writing, the results are shared with the JHSC or HSR, multi-disciplinary team and the employer.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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### Legislation Review

1. Obtained and reviewed the specific legislation, guidelines and policies that apply to workplace violence prevention in your workplace, e.g. OHSA and regulations, OHRC, CNO references, collective agreement, employer policies, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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### Measures and procedures have been developed in writing, established and put into effect, and include but are not limited to:

1. A measure (personal panic alarm devices and system) and procedure for summoning immediate assistance when workplace violence occurs or is likely to occur. (e.g. personal panic alarms linked to security with	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
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GPS/Wireless type locating capability and training on care, use and limitations).	
2. A crisis management/chain of command team is established and their roles and responsibilities are clearly outlined in a procedure (who responds first, who are first complaints reported to, who is next in line to receive the complaint if that individual is not available or does not act upon the complaint?).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
3.A procedure that outlines how and who staff will report incidents to, (employees must know who and how to report – including reporting to the police).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
4.A procedure that outlines the employer's reporting obligations to WSIB, MLITSD, JHSC or HSR and the union.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
5.A procedure to bring unresolved complaints to the Board of Directors is in place.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
6.A safety plan for the victim(s) to ensure their protection (i.e. staff scheduling, work re-assignments, transfers, screening calls and ensuring information about the victims schedule/ vacations/department transfer etc. are not revealed, and assistance for the worker to work with police, courts or other organizations who may already be involved).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
7.Measures and procedures for the health and safety of workers, as it relates to the development of a specialized care/behavioural crisis plan and/or safety plan for individuals who are known to have assaulted workers in the past, have a history of violent behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

to any person in any setting and who are or may be a risk to worker safety.	
8.Emergency/Crisis Response (code white, code purple, code black).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
9.Employee support post-incident – debriefing, legal, protection.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
10.A procedure for conducting incident investigation, including root cause investigation, follow-up/resolution. The procedure should outline what steps and timelines staff can expect from an investigation, who conducts investigations (e.g. Occupational Health, manager, JHSC/HSR).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
11.A procedure for the communication of investigation and incident resolution to appropriate workplace parties (i.e. complainant, Union President, JHSC or HSR, Human Resources, Occupational Health and Safety manager and co-workers).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
12.Administrative work practice procedures (e.g. No Access Policy, staffing, etc.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
13.Flagging measures and procedures (visual and electronic) that will identify, alert and track patients/residents/clients with a history of violent behavior, their triggers, behaviours and safety measures needed to protect all workers at risk.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

14.The employer uses the Public Services Health and Safety Association Violence Assessment Tool to proactively assess patient risk of violence.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
15.The employer has established a memorandum of understanding with the police to share and receive information about a person with a history of violent behaviour.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
16.A procedure is in place to ensure early assessment of possible formed patients by a psychiatrist.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
17. A Procedure for Certification under the <i>Mental Health Act</i> that also protects workers.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
18.System for alerting staff to other persons (e.g. visitors) with a history of violent behaviour who they may encounter in the course of their work.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
19. Appropriate procedures on use of restraints including clarity on the differences between the MOHLTC and CNO. The procedure must also contain clear guidance for staff on appropriate and available personal protective equipment (PPE) in varying situations and must highlight the procedures staff can take to protect themselves during a restraint procedure.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
20.Procedures outlining all security and crisis responses (e.g. lock-down drills, code white response and assistance, etc.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
21.Procedure to assess all code whites to determine what root cause/triggers of the aggression was, that	<input type="checkbox"/> Yes

includes steps to prevent recurrence and a process to share findings where they can be applied system-wide/other units.	<input type="checkbox"/> No <input type="checkbox"/> In Progress
22.Measures and procedures to deal with a surge in patient population, acuity, patient flow, staff absences that can create unsafe staff to patient ratios, etc. The surge procedure clearly outlines the roles and responsibilities of all physicians, staff and security in the event of a surge of patients. The procedure to be used when the minimum number of staff (including registered nurses), security and physicians does not adequately protect workers.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
23.Based on risk assessment all control measures identified have been established/purchased (For specific suggestions see Appendix C).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
24.Measures and procedures when visitors are required to enter into secured forensic units that deal with safe work practices, the nature and type of work, the control and safe removal of contraband items, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
25.Process for evaluation and review is in place, ensuring ongoing collection of indicators and demonstration that policy/program enhancements were made immediately where deficiencies sited so policy and program continues to protect workers.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
26.Process in place to ensure, as a minimum, that the policy/program is reviewed annually in consultation with JHSC or HSR or more often on the advice of the JHSC or HSR or when there is a change in circumstances that may affect the health and safety of a worker.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

## Communication

1.Workplace Violence Prevention Policy/Program has been communicated throughout organization – documented evidence.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
2.A crisis management/chain of command team is established and their roles and responsibilities clearly outlined in a procedure (see measures and procedures above).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

## Training and Education

1.Information, instruction, training and education of the policy, all measures and procedures contained in the program, including in-classroom training on de-escalation, self-protection/self-defence, safe take down and restraints. In the absence of security, use of force, sharp-edged weapons and other advanced physical skills that security guards are trained to are developed, established and provided in consultation with the JHSC or HSR for all new and existing employees, and has been completed and training records are maintained.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress  Annual Refresher Training: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
2.Education includes awareness of violence and abusive relationships (domestic violence), reaching out to co-workers and skill building.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
3.Employers, supervisors and physician leaders have been trained to identify signs of abuse and to respond appropriately to employees/workers/staff who are victims and to perpetrators of domestic and all forms and sources of violence.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress



## APPENDIX B:

### Employers' Minimum Requirements Checklist re: Violence/Harassment

HAS YOUR EMPLOYER:

Check Yes or No:



1.Prepared a Policy with respect to workplace violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.Prepared a Policy with respect to workplace harassment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.Posted a written copy of the violence and harassment policy in a conspicuous place in the workplace where more than six workers are regularly employed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.Assessed the risks of workplace violence that may arise from the nature of the workplace, the type of work or conditions of work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.Advised the JHSC or an HSR or workers (where there is no JHSC or HSR) of the results of the risk assessment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.Provided a copy of any written assessment to the JHSC or HSR?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.Where there is no JHSC or HSR, provided a copy of the assessment to workers on request or advise the workers how to obtain copies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.Reassessed the risks of workplace violence as often as necessary to ensure the related violence policy and program continues to protect workers and advised the JHSC or HSR of the results of the assessment and provided a copy, if the assessment is in writing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



13. Taken every precaution reasonable in the circumstances for the protection of workers with respect to workplace violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Taken every precaution reasonable in the circumstances for the protection of the worker when aware or ought reasonably to be aware that domestic violence may occur in the workplace that would likely expose the worker to physical injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Provided workers with information and instruction appropriate for the worker on the contents of the workplace violence policy and program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Provided workers with information and instruction appropriate for the worker on the contents of the workplace harassment policy and program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Provided workers with information, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour they can expect to encounter in the course of their work, where the risk of violence is likely to expose the worker to physical injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. In workplaces covered by the <i>Health Care and Residential Facilities Regulation</i> (i.e. hospitals, long-term care homes), consulted the JHSC or HSR when developing, establishing and putting into effect the workplace violence and harassment measures and procedures for the health and safety of workers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. In workplaces covered by the <i>Health Care and Residential Facilities Regulation</i> , ensured violence and harassment measures and procedures are written?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. In workplaces covered by the <i>Health Care and Residential Facilities Regulation</i> , consulted the JHSC or	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HSR in developing, establishing and providing training and educational programs related to violence and harassment in health and safety measures and procedures for workers that are relevant to the workers' work.		
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## APPENDIX C:

### Checklist of Some Specific Controls/Measures to Consider

Use this checklist along with your employer's risk assessment to identify controls/measures and procedures for your workplace. Based on the findings of the risk assessment and this checklist, prepare a written recommendation, present it at your next JHSC meeting and ensure a copy of the signed recommendations are forwarded to the employer from the JHSC or where there is no consensus from the JHSC, the single worker co-chair can submit them on her/his their own. (HSRs should present the recommendations directly to the employer). The employer is obligated to provide a written response within 21 days. (See Appendix E and F for sample recommendations to the employer). A Word version of these tools and another sample recommendation of ONA's top10 recommendations can also be found by logging on to ONA website at [www.ona.org](http://www.ona.org)

Change, delete or disregard items that are not relevant to your organization.

#### Controls/Measures

1. Security – Implement 24/7 electronic security using a system that is live monitored at all times from a control centre and that has the ability to communicate with protection services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
2. Alert public that cameras are being used.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
3. Your employer has an adequate number of 24/7 trained security guards who can be hands on and who are trained as a minimum to the same standards that the Michael Garron Hospital guards are trained.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
4. Provide panic alarms/panic buttons, voice-activated communication systems, linked directly to security with GPS/Wireless type locating capability, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

5. Provide two-way communication devices, e.g. cell phones, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
6. Install telephones in isolated areas.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
7. Implement a buddy system	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
8. Code White Team is in place and conducts mock code whites.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
9. Establish police liaison/assistance and police sharing of information related to a risk of violence or history of violent behaviour to any person in any setting.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
10. Access control measures – like posting security personnel or using coded access cards to control exits and entrances, restrict building access especially at night or on weekends.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
11. Name tags – Provide for staff without using last names.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
12. Badge system for patient/resident/client and visitors.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

<p>13. Signage – Post signage throughout hospital/workplace that makes it clear there is zero tolerance for violence, and post signs to prevent visitors from entering into restricted areas.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>14. Flagging system – Implement a system that alerts staff to patients/residents/clients with a history of violent behaviour they can expect to encounter in the course of their work, where the risk of violence is likely to expose the worker to physical injury. The system also tracks the triggers to the behaviour.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>15. System to identify all other persons with a history of violent behaviour they can expect to encounter in the course of their work, where the risk of violence is likely to expose the worker to physical injury.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>16. Provide a visitor sign-in book to document who is entering and existing the facility.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>17. Install curved or circular mirrors at hallway intersections.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>18. Replace all broken locks and windows.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
<p>19. Doors and stairwells – ensure clear safety-glass panels are installed in all doors to stairwells, etc. so user can see if another person is on the far side of door.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

20. Install physical barriers in areas where workers greet or interact with the public; enclose nursing stations in shatterproof glass to prevent patients/residents/clients/visitors from reaching in or throwing objects at nurses.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
21. Furniture – Strategically place furniture to prevent patients/residents/clients/visitors from wandering into work areas or entrapping staff and to prevent hiding areas; keep furniture to a minimum, ensure furniture is rounded with padded edges and/or if possible secure it to the floor. Avoid accessories that could be used as weapons.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
22. Workstations – Organize workstations and areas to minimize physical contact; use wide desks, tables or counters, raise height of counters etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
23. Establish a worker safe room in designated areas with telephone and/or security/alarm access to the outside and peep hole.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
24. Bathroom/lounge areas for staff should be lockable, have telephone and/or security/alarm access to the outside and peephole.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
25. Waiting room enhancements – Use calming paint colours, provide reading materials, television, reduce background noise, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
26. Posting wait times at triage/registration and provide regular information about delays.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress



27. Lighting enhancements.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
28. Noise barriers – Install sound-absorbing panels to control noise.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
29. Discourage theft – Lock cupboards/storage areas, secure sharps storage, change entry system to the medication room and remove any internal deadbolts.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
30. Provide designated parking.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
31. Provide panic stations within parking garages and walkways to the garage supported and connected to the electronic security system.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
32. Ensure safe staffing ratios.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress
33. Grounds and parking lot design – Make sure entrances and exits are well marked, ensure parking areas and entrances are well lit at night, use security patrols and vary times for patrols, remove or trim tree branches and bushes, provide parking lot escort services after hours or when a risk has been identified etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress

## APPENDIX D:

### Next Steps to Address Violence/Harassment

ONA worked tirelessly for legislation and other measures to make our workplaces safe from threats of violence. The 2010 and 2016 amendments to the *OHS*A are not perfect, but they represent significant progress. Now that we have this improved legislation, we must use it and all other relevant sections of the *OHS*A and the *Health Care and Residential Facilities Regulation*. We need to step up our efforts to impress on our employers that they must take every precaution reasonable to protect us from violence/harassment, and we need to engage the assistance of the MLITSD whenever they fail. Therefore, we are asking leaders to work with the ONA members and ONA members of JHSCs or the HSR to:

1. Report all hazards in writing to the supervisor/employer.
2. If the issue is not resolved or there is an imminent risk to worker safety that cannot wait for the JHSC meeting or for the JHSC or HSR to make recommendations or cannot wait for the supervisor to take action, the union will escalate the issue as high as necessary, as quickly as necessary to the CEO or most senior executive if your organization does not have a CEO. If no immediate action is taken, the union will escalate it quickly to the MLITSD and to the union to protect workers. (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training and Skills Development (MLITSD)" at [www.ona.org](http://www.ona.org) Appendix H – Form to Report an Unresolved Safety Hazard and Resources in Appendix J).
3. If the risk is not imminent, place the issue of workplace violence on the agenda of your next JHSC meeting. The legislation requires employers to prepare workplace violence and harassment policies, post written policies in a conspicuous place in the workplace (in workplaces with six or more regularly employed workers), assess and reassess the risk of workplace violence, develop programs (not just a policy) with respect to violence and harassment, and provide information and instruction to workers. (HSRs should discuss this issue and request the information directly from the employer).
4. Remember, it is not the JHSC or HSR's job to write the policies or programs for the employer, but in accordance with Sections 8 and 9 of the *Health Care and Residential Facilities Regulation* (applicable to hospitals and long-term care homes), the measures and procedures contained in the program must be in

writing and must be developed, established and put into effect in consultation with the JHSC or HSR. They must also be reviewed, and training and educational programs (not just information and instruction) must also be developed, established and provided, in consultation with the JHSC or HSR. Therefore, the JHSC or HSR should:

- a) Recommend in writing an immediate review of existing violence and harassment policies, measures and procedures/programs, training and all risk assessments, and where there are none, or where they are deficient, recommend that they be developed, revised or improved forthwith. (HSRs should present the information and recommendations directly to the employer). (See Appendix E for a sample recommendation and Appendix F for additional considerations for a recommendation. A sample of ONA's top 10 recommendations and Word versions of all the recommendations can be found at [www.ona.org](http://www.ona.org) ).
  - b) Point out that the Public Services Health and Safety Association (PSHSA) can assist your employer.
5. Caucus with all worker members of the JHSC for at least one hour before the meeting (Section 9 (34) *OHS*A) to discuss this issue and worker expectations and gain support for the recommendations.
  6. At the JHSC meeting, discuss and get support for all the recommendations and have the co-chairs send the signed and dated recommendations to the employer (usually the CEO or most senior executive if there is no CEO in your organization).
  7. If the JHSC does not agree to send the recommendations to the employer, either JHSC co- chair (or HSR) may send the written recommendations to the employer and the *OHS*A gives your employer 21 days to respond in writing, with a time frame to implement the recommendations it agrees with and give reasons why the employer disagrees with any recommendations that the employer does not accept. (Section 8 (10) and (12) of the *OHS*A for HSRs, and Section 9 (20) and (21) of the *OHS*A for the JHSC).
  8. If the employer does not respond within 21 days or if their 21-day response does not adequately resolve the concerns raised on the written recommendation, elevate the issue as high as necessary with the government (call MLITSD), and the union as fast as necessary to protect workers. (See ONA's "Guideline: When to Call the Ministry of Labour, Immigration, Training

and Skills Development (MLITSD)” at [www.ona.org](http://www.ona.org) Appendix H – Form to Report an Unresolved Safety Hazard and Resources in Appendix J).

9. In long-term care, ensure that the employer’s policy is aligned with their requirements under the *LTCHA*, including the requirements to report abuse and the use of any restraints.
10. File a grievance if the matter is not resolved and your collective agreement permits. Consult your Bargaining Unit President/LRO.

## APPENDIX E:

### Sample – Recommendations to Employer

Date: \_\_\_\_\_ Hand delivered to: \_\_\_\_\_

(Insert name of Employer) (Insert address of Employer)

Pursuant to Section 9 (18) of the *Occupational Health and Safety Act (OHSA)*, among our functions as a Joint Health and Safety Committee, we are to:

- “Identify situations that may be a source of danger or hazard to workers.
- Make recommendations to the employer and the workers for the improvement of their health and safety.
- Recommend to the...employer and the workers the establishment, maintenance and monitoring of programs, measures and procedures respecting the health and safety of workers, and the trade union representing the workers.”
- Powers of co-chairs

Section 19.1 of the *OHSA* states, “if the committee has failed to reach consensus about making recommendations under subsection (18) after attempting in good faith to do so, either co-chair of the committee has the power to make written recommendations to the constructor or employer.

As such, we (if no consensus reached by JHSC, the worker co-chair should replace the “we” with “I”) have identified the following source(s) of danger or hazard, and/or concern(s), at [insert address of employer] and/or provide the following recommendations:

## Identified Hazards or Dangers and/or Concerns and their Associated Recommendations

Hazard/Concern	Recommendations
<p>1. Risk of exposure to violence</p>	<p>A. It is recommended the employer forthwith <b>(prepare) (revise)</b>, in consultation with the JHSC or HSR, a workplace violence policy. The policy should:</p> <ul style="list-style-type: none"> <li>• <b>(Show) (be amended to show)</b> an employer's commitment to protecting workers from workplace violence.</li> <li>• <b>(Address) (be amended to address)</b> violence from all possible sources (customers, clients, employers, supervisors, doctors, workers, strangers and domestic/intimate partners).</li> <li>• <b>(Outline) (be amended to outline)</b> the roles and responsibilities of the workplace parties in supporting the policy and program.</li> <li>• <b>(Be dated and signed) (amended to be dated and signed)</b> by the highest level of management at the workplace.</li> <li>• Be posted in a conspicuous place in the workplace.</li> </ul> <p>B. It is recommended the employer, in consultation with the JHSC or HSR, demonstrate how they will <b>(develop) (amend to improve)</b> and maintain a</p>

Hazard/Concern	Recommendations
	<p>program to implement the violence policy; such program to include measures and procedures:</p> <ul style="list-style-type: none"> <li>• To control the risks of violence, including but not limited to those identified in risk assessments, and risks of exposure to domestic violence, workplace inspection reports and incident and accident/illness reports.</li> <li>• For summoning immediate assistance when workplace violence occurs or is likely to occur by implementing personal panic alarms/system linked to security.</li> <li>• For workers to report incidents of workplace violence to the employer or supervisor, and set out how the employer will investigate and deal with incidents or complaints.</li> <li>• To provide information to a worker, including personal information (reasonably necessary to protect workers) related to a risk of violence from a person with a history of violent behaviour, if the worker can be expected to encounter the person in the course of work, and the risk of violence is likely to expose the worker to injury.</li> </ul>

Hazard/Concern	Recommendations
	<p>C. It is recommended the employer, in consultation with the JHSC or HSR demonstrate how and when they will:</p> <ul style="list-style-type: none"> <li>• <b>(Assess) (re-assess)</b> the risk of workplace violence that may arise from the nature of the workplace, type or conditions of work, taking into account the circumstances of the workplace and circumstances common to similar workplaces.</li> <li>• Re-assess as often as necessary to protect workers.</li> <li>• Advise the JHSC or HSR of the results of the assessment and provide a written copy.</li> </ul> <p>D. It is recommended the employer, in consultation with the JHSC or HSR demonstrate how they will:</p> <ul style="list-style-type: none"> <li>• <b>(Develop) (amend) (deliver)</b> appropriate information, instruction, training and education to workers on the contents of the workplace violence policy and program, mindful that: <ul style="list-style-type: none"> <li>○ Appropriate training will equip a worker to: <ul style="list-style-type: none"> <li>▪ Know how to summon assistance when violence occurs or is likely to occur and report incidents.</li> <li>▪ Know how the employer will respond.</li> </ul> </li> </ul> </li> </ul>



Hazard/Concern	Recommendations
	<ul style="list-style-type: none"> <li>▪ Carry out all measures and procedures that are part of the workplace violence program (e.g., work refusal, reporting and investigation, safety huddles, debrief, code white etc., security, search, seclusion room safe entry and exit, personal panic alarms use, care and limitations, etc.)</li> <li>▪ Crisis intervention training that includes de-escalation, self-protection/self-defense, restraints, safe take-down, break-free/blocking, and in the absence of security, all training as a security guard should be based on the CGSB standard, including physical skills such as use of force, sharp edged weapons etc.</li> <li>• <b>(Develop) (amend) (deliver)</b> training that will make supervisors competent in dealing with reports/incidents of violence and investigating violent incidents and hazards.</li> </ul>

<p>2. Risk of exposure to harassment</p>	<p>A. It is recommended the employer forthwith <b>(prepare) (revise)</b>, in consultation with the JHSC or HSR, a workplace harassment policy and post it in a conspicuous place in the workplace.</p> <p>B. It is recommended the employer, in consultation with the JHSC or HSR, <b>(develop) (amend to improve)</b> and maintain a program to implement the harassment policy; such program to include measures and procedures:</p> <ul style="list-style-type: none"> <li>• For workers to report incidents of harassment to the supervisor or employer.</li> <li>• Set out how the employer will investigate and deal with incidents and complaints of harassment.</li> <li>• For the employer to cause an investigation of any incident or complaint.</li> </ul> <p>C. It is recommended the employer, in consultation with the JHSC or HSR demonstrate how they will:</p> <ul style="list-style-type: none"> <li>• <b>(Develop) (amend) (deliver)</b> appropriate information, instruction, education and training to workers on the contents of the workplace harassment policy and program.</li> <li>• <b>(Develop) (amend) (deliver)</b> training that will make supervisors competent in dealing with reports/ incidents of harassment.</li> </ul>
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Pursuant to Section 9 (20), an employer who receives written recommendations from a committee or co-chair shall respond in writing within 21 days. Therefore, we/I look forward to receiving your written response to our/my recommendations within 21 days, by [enter date]. (HSRs refer to Section 8 (12) of the *OHSA*)

We/I anticipate that your written response will include all information pursuant to the *OHSA* Section 9 (21), which states: "A response of a constructor or employer under subsection (20) shall contain a timetable for implementing the recommendations the constructor or employer agrees with and give reasons why the constructor or employer disagrees with any recommendations that the constructor or employer does not accept." (HSRs refer to Section 8 (12) & (13) of the *OHSA*.)

Please sign below.

\_\_\_\_\_, Worker Co-Chair, Joint Health and Safety Committee

\_\_\_\_\_, Employer Co-Chair, Joint Health and Safety Committee

C:     Post for the workers  
           Copy to JHSC or HSR  
           Local Bargaining Unit \_\_\_\_\_  
           Other unions

## APPENDIX F:

### Joint Health and Safety Committee Recommendations – Additional Considerations

To obtain a copy of ONA's top 10 recommendations that you can revise based on the unresolved issues related to violence in your workplace, go to [www.ona.org](http://www.ona.org)

Depending on the size and complexity of your workplace, and the maturity of your violence prevention planning to date, you may be ready to consider integrating more specific elements into your JHSC recommendation to the employer, including:

#### Risk Assessments

- Conducting a physical assessment of the workplace environment and an assessment of patient/resident/client behaviours, triggers, acuity, population and patient flow. Conducting staff surveys and reviewing accident/illness data to determine where the highest areas of risk are and the types of incidents that are occurring. The assessment should also consider any previous JHSC recommendations made, any recommendations/results from previous investigations to ensure they have been implemented and if so, are they still protecting workers. It should also consider what current measures, procedures and training the employer has in place as part of its workplace violence program and make recommendations for either new measures, procedures and training or revise existing ones where gaps are identified, and the current program no longer protects workers.
- Conducting a review of security measures in situations where employees/staff are exposed to dangers in the workplace from other staff/patients/residents/clients, visitors or the public. Possible considerations for a recommendation could be increased security staff, "lock-down" drills, specific training for security in domestic violence and workplace violence and, as a minimum, the same training that the security staff receive at Michael Garron Hospital (see page 33 for more detailed information about their specific training).

## Controls/Measures

- a) Two-way communications systems.
- b) Intervention security (in-house security).
- c) Link to the police.
- d) Police memorandum of agreement to share/receive information about a person with a history of violent behavior.
- e) Emergency-response teams.
- f) Increased video surveillance cameras.
- g) Personal alarms/voice activated devices linked to security with GPS/wireless locating capability.
- h) Panic buttons
- i) Relocating existing panic buttons in offices to be accessible to the user.
- j) Metal detectors/wands.
- k) Adequate staffing.
- l) Electronic and visual flagging procedure/risk identification, communication (electronic, verbal and visual) and tracking system to alert staff to patients/residents/clients with a history of violent behaviour who they may encounter in the course of their work. The system must also track the patients/residents/clients' behaviours, identify all triggers and provide specialized care plans and worker safety plans.
- m) Escape avenues.
- n) Safe rooms with peep holes and communication ability.
- o) Access control.
- p) Code white policy and step-by-step procedure to outline; the steps for a coordinated team response in situations where workers are threatened by verbal and physical abuse/assault; mock code whites and a debrief that includes a determination (root cause analysis) of what triggered or caused the aggression/assault (e.g. patient with unknown claustrophobia acted out when asked to shower in a small space – solution: flag file of patient condition, triggers and solution, which is “do not place patient in any enclosed spaces,” and share solution on a solutions page facility-wide and add to triage and pre-admit screening questions, such as, “is there anything or any condition you have that we should be aware of that could cause you anxiety or cause you to act out while here.”)
- q) Security response procedure.

- r) Patient/resident/client search procedure.
- s) System for alerting staff to other persons with a history of violent behaviour who they may encounter in the course of their work.
- t) Establishing clear codes of conduct, supported by procedures that are conducive to a culture that encourages and supports early identification and intervention, meaningful discussion (including mechanisms to support complainants who are reluctant to participate in formal processes), appropriate actions and follow through, etc.
- u) Establishing a procedure that sets out how the employer will take every precaution reasonable in the circumstances for the protection of the worker if they become aware, or ought reasonably to be aware, that domestic violence that would likely expose a worker to physical injury may occur in the workplace.
- v) Work refusal procedure.

## Reporting/Investigating

- a) Developing a chain of command and reporting/response procedure in the policy/program to respond to threats of domestic and workplace violence, abuse, harassment or other legitimate complaints that occur in the workplace or that are work-related.
- b) Outlining in a procedure how and to whom incidents should be reported, including information about contacting the police directly, which should specifically direct that such reporting of abuse ought not be left as exclusively the responsibility of the victim.
- c) Outlining in a procedure that all employees/physicians who are not directly involved may report a concern, but must report witnessed abusive/violent behaviour and indicate that reports must be acted upon regardless of whether they are verbal or written.
- d) A police transfer of custody protocol and memorandum of understanding between the police and the health care facility to provide information on a person with a history of violent behaviour, including behaviours, triggers, specialized care strategies and worker safety plans.
- e) A safety plan for the victim(s) to ensure that a number of safety/security measures are in place for their protection. Staff scheduling and work reassignments and transfers should be accommodated in situations involving any form or source of workplace violence.
- f) A process to ensure a thorough investigation of all claims of misconduct present in the workplace. This process is to also outline that mediation should not be

utilized for incidents involving any form or source of violence because of the power imbalance between the parties in these circumstances.

- g) Outlining a procedure that requires steps taken towards incident resolution to be communicated to appropriate workplace parties (i.e. complainant, workplace representative, JHSC or HSR, Human Resources, Occupational Health and Safety manager and coworkers) in a timely manner.

## Education/Training

- a) Violence awareness, de-escalation techniques, hands-on break-free/blocking techniques, self-protection/self-defence, restraints, and in the absence of security use of force, sharp-edged weapons, safe take down and restraints, and training on all of the measures and procedures contained in the violence/harassment program.
- b) Awareness of domestic violence and abusive relationships and how to reach out to co-workers for assistance, and an awareness to action about helpful and safe interventions for victims and perpetrators. Skill-building interventions that engage both professionals and non-professionals in practicing what they might say and do in such circumstances should be utilized in training initiatives.
- c) Training of employers and managers and, specifically within the hospital context, physician leaders, to identify signs of abuse and to respond appropriately and quickly to employees/workers/staff who are victims and perpetrators of domestic and all other forms and sources of violence.

## Interim Measures

Until recommendations are acted on and changes/improvements are complete, take interim measures, such as increased security and staffing, to ensure the safety and security of workers.

## Resources

Consider using Violence Aggression, Responsive, Behaviours resources developed by the PSHSA and other Health Care Leadership Table resources to support your recommendations and implement a comprehensive violence prevention program found at <https://workplace-violence.ca/> and the sample violence policy attached (see Appendix G).

## APPENDIX G:

### Sample Workplace Violence Prevention Policy

A word version of this policy can also be found by logging on to ONA's website at [www.ona.org](http://www.ona.org)

**(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, sensitivity and dignity. Violence in the workplace can have devastating effects on the quality of life for our employees, our patients/residents/clients and on the productivity of the organization.

#### **Purpose**

(Name of organization) is committed to providing a working environment free of violence. The purpose of this policy is to identify behaviour that constitutes workplace and work-related violence and to provide preventative and mitigating procedures, including steps for preventing, summoning immediate assistance, reporting, investigating and resolving incidents of workplace violence. All workplace parties must be familiar with their individual responsibilities for prevention and corrective action. (Name of organization) has consulted the Joint Health and Safety Committee (JHSC) or Health and Safety Representative (HSR) and the following legislation governing workplace violence in Ontario to establish this policy.

- *Occupational Health and Safety Act.*
- *Criminal Code of Canada.*
- *Ontario Human Rights Code.*
- *Workplace Safety and Insurance Act.*
- *Compensation for Victims of Crime Act.*
- *Regulated Health Professions Act.*
- *Occupier's Liability Act.*
- *Public Hospitals Act.*



There are four main categories of workplace violence:

- **External:** Thefts, vandalism, assaults by a person with no relationship to the workplace.
- **Client/Customer:** Physical or verbal assault towards an employee by a client/family member or customer.
- **Employment related:** The violent person (physical or verbal) has or had some type of job- related involvement with the workplace.
- **Domestic Violence:** Personal relationship.

### Policy Statement

The management of **(Name of organization)** recognizes the potential for workplace and work- related violence and will make every reasonable effort to identify all potential sources of violence in order to eliminate and/or minimize risks. **(Name of organization)** refuses to tolerate any type of behaviour that may constitute or lead to, violence within or related to, the workplace. **(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.

The *OHSA* 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

**(Name of organization)** is committed to taking every precaution reasonable to protect workers from workplace violence as defined in the *OHSA*. In addition, **(Name of organization)** is committed to taking every precaution reasonable to protect workers from psychological injury/illness from any aggressive behaviour, and threats of aggressive behaviour. **(Name of organization)** recognizes harassment may be a precursor to violence, and as such embraces harassment – be it a course or a single egregious act of vexatious conduct – as within the scope of our violence prevention policy, program and activities.

All managers, supervisors and employees are responsible for following safe work practices, the policy and the procedures outlined in the workplace violence prevention program. Management is responsible for implementing and maintaining the policy and procedures.

(**Name of organization**) encourages and supports employee involvement and commitment to the design and implementation of the workplace violence prevention program and will ensure that such design and implementation is conducted in consultation with the JHSC or HSR and addresses all forms and sources of workplace violence.

The management of (**Name of organization**) is responsible for ensuring that all health and safety policies and procedures, including workplace violence, are clearly communicated and understood by all employees, through both general and site-specific training, and annual review of the policy/program. Managers and supervisors are expected to enforce this policy and program requirements fairly and consistently throughout the organization and are accountable for any failure to respond to and investigate allegations of workplace violence.

### **Violence in the Workplace Prevention Program**

A violence prevention program of measures and procedures to operationalize our policy, will be implemented. The violence prevention program can improve the quality of the working environment and substantially decrease the risk of workplace violence.

Elements of the workplace violence prevention program include:

- Express, demonstrated management commitment.
- Employee and JHSC or HSR involvement.
- Communication and training of the violence policy and prevention program.
- Hazard/risk assessment.
- Establishment of violence prevention, control/measures, which include hazard prevention controls, methods of summoning immediate assistance when workplace violence occurs or is likely to occur, responding to (e.g. code white), reporting and investigating incidents of violence, risk identification/alerts/tracking system (e.g. flagging system)
- Education and training of new and existing employees, volunteers, contractors, visitors, etc. about the policy and relevant portions of the program.
- Evaluation of the policy and program

## Work-related Violence

It is important to note that workplace violence can also occur outside of work settings and in cases of domestic violence, can spill over into the workplace. It can occur during work-related functions at off-site locations such as conferences, social events, or visits to clients' homes. It can also happen in an employee's home, yet be work related: for example, threatening telephone calls from co-workers, clients, or managers. Workplace violence can be committed by anyone: employees, supervisors, managers, clients (patients, residents, customers), students, contract workers, visitors, families of clients (patients, residents, customers), families, friends, ex-partner of employees, or unauthorized intruders.

## Roles and Responsibilities of Workplace Parties

### Employer (Including Directors)

- Take every precaution reasonable in the circumstances for the protection of workers.
- In consultation with the JHSC or HSR, take appropriate action to eliminate/reduce identified hazards/risks by establishing controls/measures and procedures.
- Identify and alert staff to violent patients/residents/clients/persons and hazardous situations.
- In consultation with the JHSC or HSR, conduct regular hazard/risk assessments and provide a copy of the assessment to the JHSC or HSR.
- In consultation with the JHSC or HSR, develop, establish and put into effect measures and procedures for the safety of workers (e.g. security guards, flagging, summoning immediate assistance, code white etc.).
- In consultation JHSC or HSR, develop, establish and provide training and education of all employees. Conduct unit specific training and ensure all staff are trained on the Workplace Violence Prevention Policy/Measures/Procedures/Program, including domestic violence in the workplace
- Ensure measures and procedures identified in the violence program are carried out and that management is held accountable for responding to and resolving all complaints of violence.
- Modeling and integrating safe behaviour into day-to-day operations.
- Provide appropriate means to summon immediate assistance when workplace violence occurs or is likely to occur.

- Provide appropriate reporting and response measures.
- Review all reports of violence and/or threats of violence in a prompt, objective and sensitive manner. This includes a review of all investigations associated with violence-related incidents.
- Take appropriate corrective action.
- Assist the JHSC or HSR in the carrying out of any of their functions
- Facilitate medical attention and appropriate support for all those either directly or indirectly involved in a violent incident.
- Conduct an annual review of the violence prevention policy/program in consultation with the JHSC or HSR.
- Ensure any deaths or critical injuries have been reported immediately to a MLITSD inspector, the police (as required), the JHSC, the HSR and trade union and are investigated with the JHSC or HSR, and that a report goes to all parties in writing within 48 hours of the occurrence on the circumstances of the occurrence, containing such information and particulars as the OHSA and regulations prescribe. Facilitate immediate JHSC worker member or HSR investigations.
- Ensure all accidents causing injury or illness are reported to the JHSC or HSR, the Union and MLITSD where applicable within four days of the occurrence containing all of the prescribed information contained in the **O. Reg 420/21, Notices and Reports Under Sections 51 To 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents.**
- Ensure all accidents/illnesses are reported to WSIB 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.

### **Managers/Supervisors**

- Must be “competent” as defined in the OHSA.
- Take every precaution reasonable in the circumstances for the protection of workers.
- Ensure workers are trained on all measures and procedures identified in the violence program and that the measures and procedures are carried out.
- Must enforce policy and procedures and monitor worker compliance.
- Conduct risk assessments and reassess the risk of violence to workers as often as necessary to ensure the policy and program continue to protect workers.

- Identify training needs and conduct unit specific training. Ensure all staff are trained on the Workplace Violence Prevention Policy/Program, including domestic violence in the workplace.
- Identify and alert staff to violent patients/residents/clients/persons and hazardous situations.
- Shall promptly respond to and investigate all allegations and incidents of workplace violence, whether written or verbal, using the organization's accident investigation procedure and form and contact the police department as required.
- Determine the root cause of the incident and implement preventive measures.
- Facilitate medical attention for employee(s) as required.
- Ensure that debriefing is completed for those either directly or indirectly involved in the incident.
- Contact the Human Resources Department to ensure the employee receives further counselling regarding their legal rights.
- Support staff throughout the process following an incident and, in the return,-to-work process, including developing a safety plan as needed.
- Track and analyze incidents for trending and prevention initiatives.
- Immediately report a death or critical injury to an MLITSD inspector, the police (as required), JHSC, the HSR and trade union, and investigate with the JHSC or HSR and report to all parties in writing within 48 hours of the occurrence the circumstances of the occurrence, containing such information and particulars as the regulations prescribe. Facilitate immediate JHSC worker member or HSR investigations.
- Assist the JHSC or HSR in carrying out of any of their functions.
- Issue a report to the employer and WSIB on all accidents/illnesses 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. Ensure all accidents causing injury (where a worker is unable to perform usual duties or requires medical attention) or illness (where the employer is advised by or on behalf of the worker of an occupational illness or that a claim for WSIB has been made) are reported to the JHSC or HSR, the union and MLITSD where applicable within four days of the occurrence containing all of the prescribed information contained in the O. Reg 420/21, *Notices and Reports Under Sections 51 To 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents*.

- Ensure there is a review at least annually of the workplace violence prevention policy/program.

**Employees (Workers/ Physicians/Contractors/Individual Managers and Directors)**

- Participate in violence prevention policy/program education and training programs in order to be able to appropriately respond to any incident of workplace violence.
- Understand and comply with the violence in the workplace prevention policy/program and all related procedures.
- Actively participate in the management of violent/aggressive behaviour.
- Report all hazards, incidents/injuries of violence and/or threats of violence to their manager or supervisor immediately, completing the workplace violence incident report form.
- Inform the JHSC or worker member of the JHSC or HSR about any concerns about the potential for violence in the workplace.
- Contribute to hazard/risk assessments.
- Seek support from available resources as required when confronted with violence or threats of violence.
- Seek medical attention.
- Participate in a review at least annually of the workplace violence prevention policy/program.

**JHSC or HSR**

- Identify situations that may be a source of danger or hazard to workers (e.g. during regular workplace inspections, through analyzing accident/illness reporting information) and make recommendations to the employer for the improvement of the health and safety of workers.
- Be consulted about and make recommendations to the employer about the development, establishment and implementation of a violence policy, controls/measures and procedures (violence prevention program).
- Be consulted and make recommendations to the employer to develop, establish and provide training in violence policy, controls/measures and procedures (the violence prevention program).
- Review at least annually the workplace violence prevention policy/program.

- Be notified immediately by the employer in the event of a critical injury or fatality and review the employer's reports to the MLITSD of any critical injury or fatality.
- The JHSC worker designate or HSR should immediately investigate all critical injuries or death related to violence.
- Forthwith review, analyze investigation of critical injury or death and make recommendations in writing to the employer as appropriate.
- Have a worker member of the JHSC or HSR present during any work refusal.
- Review as soon as practicable, written notice (to be provided by employer within four days of the accident/illness where there is no critical injury or fatality), containing all information as the *OHSA* and regulations prescribe where any person is unable to perform their usual duties, requires medical attention, or where the employer is notified that a worker has an occupational illness or is advised that a claim in respect of an occupational illness has been filed for the worker.
- Be authorized to determine whether to investigate any incident of violence/harassment.

### **Summoning Immediate Assistance**

Where there is actual or the potential for workplace violence, staff will use personal panic alarms, linked to security with GPS/Wireless locating capability and follow the organization's procedure on summoning immediate assistance. (Employer to provide a link to the procedure here).

### **Reporting and Investigation**

- Workers are to report all violence-related incidents/hazards to their manager or supervisor. The worker and/or the employer may choose to call the police.
- Workplace violence incident reports are found in the incident and near-miss/hazard logs and are to be used as a reporting tool by directly forwarding a copy of the completed form to the manager. (A copy can be left in the log).
- The employer will report all injuries/illness to the MLITSD, JHSC, the HSR, union and WSIB as required by the *OHSA* and the *Workplace Safety and Insurance Act* (WSIA).
- The manager or supervisor receiving the report will investigate the report and ensure appropriate measures are taken to safeguard employees, curtail the

violence and prevent a recurrence. No report of workplace violence or risks of violence can be the basis of reprisal against the reporting employee.

- If a violent incident results in a critical injury or death to a worker, the JHSC worker designate or HSR shall investigate the incident/injury/death (s. 9 (31) *OHS*A for JHSCs, s. 8 (14) for HSRs) and will report their findings to the MLITSD and to the JHSC or HSR. The JHSC/HSR may investigate any injury resulting from violence.

### **Response Procedures**

- Workplace parties can prevent violence through an appropriate care plan, chemical/physical/environmental/social restraints where necessary and other appropriate measures and physicians are expected to be aware of appropriate use of these methods and to furnish information to staff concerning the purpose of restraints and their short-or long- term use.
- 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, JHSC or HSR reports and recommendations, monitors trends and will make recommendations for prevention and enhancements to the workplace violence prevention policy/program to the CEO or equivalent.
- These findings will be shared with the JHSC or HSR, which is consulted regarding any revision to the violence prevention policy/program, including training.
- The CEO or equivalent reviews reports of workplace violence and ensures appropriate actions have been taken.
- The managers or supervisors who investigate the reported incident of violence warn all staff who might be affected by the potentially dangerous situation(s) associated with the reported incident. The same managers or supervisors inform the employee(s) who made the report, of the outcome of the investigation to the extent necessary to optimize future safety from similar incidents.



### Emergency Response Measures

Refer to the organization's emergency response procedure (code white, staff alert). (Employer to provide a link to the procedure here).

### Supports for Employees Affected by Workplace Violence

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

- Immediately keep worker safe.
- Facilitation of medical attention.
- Debriefing (by a skilled professional).
- Provide support for cases of domestic violence.
- Develop a safety plan, as needed.
- Referrals to community agencies, treating practitioner, and employee assistance program.
- Referral to trade union.
- Completion of incident reports, WSIB accident/illness reports, reports to MLITSD, JHSC, the HSR and trade union as required under s. 51, 52 & 53 of the *OHSA* and the *WSIA*.
- Reporting to police (as required).
- Team debriefing.

### Risk Assessment

Management (with JHSC or HSR/worker involvement) assesses workplace violence hazards/risks in all jobs in the workplace. The risks of workplace violence will be reassessed as often as necessary whenever new jobs are created, or job descriptions or circumstances are substantially changed.

Management works together with employees and the JHSC or HSR to develop strategies, procedures and controls/measures for ongoing reduction of risks of workplace violence identified in the risk assessment. These include, but are not limited to, education and training, information exchange, implementing controls and reviews of practices and procedures.

**Communication**

The employer ensures the workplace violence prevention policy/program has been communicated throughout the organization and that a crisis management/chain of command team is established and their roles and responsibilities are clearly outlined in a procedure.

**Training and Education**

All existing and new employees will receive initial and annual general and site-specific training to the workplace violence prevention policy/program, which will include training on domestic violence.

Any training developed, established and provided shall be done in consultation with and in consideration of the recommendations of the JHSC or HSR.

**Policy/Program Evaluation**

The effectiveness of the workplace violence prevention policy/program is evaluated annually by management and reviewed by the JHSC or HSR.

**Accountability**

All workplace parties are accountable for complying with the policy, measures and procedures (the program) related to workplace violence. This is part of the responsibilities to comply with health and safety policy/program in the manager's, supervisor's and worker's job descriptions. Management responsibilities for enforcing policy and procedures, including investigation of and response to workplace violence are also included in health and safety components of job descriptions.

**Records**

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

**Policy Review**

This violence in the workplace violence prevention policy and program will be reviewed annually by management and the JHSC or HSR.

**Related Documents**

Workplace Harassment and Discrimination

Domestic Violence Safety Assessment

Domestic Violence Care Plan

Domestic Violence Safety Resources

Dated at \_\_\_\_\_ on \_\_\_\_\_, 20\_\_\_\_

Signed \_\_\_\_\_

(Senior Management to sign)

## APPENDIX H:

### Form for Reporting an Unresolved Health and Safety Hazard to Manager

**Recognize Violence. Report it.**

[www.ona.org/workplace-hazards](http://www.ona.org/workplace-hazards)

#### UNSAFE WORKPLACES HURT PATIENTS TOO

Being struck, threatened or otherwise abused is **not** part of your job. When these things happen, or if you know of conditions that may lead to violence, you are required by law to report them to your manager.

#### What to Report:

- When you witness or experience:
  - Threats of violence
  - Assaults (for example: spitting, pushing, pinching, hitting with a hand, fist or object, kicking, grabbing, holding, choking, stabbing, etc.)
- All injuries (scratches, bruises, sprains, fractures, etc.)
- Hazards that may contribute to violence. For example:
  - Inadequate panic alarms
  - Inadequate training
  - Potential weapons, e.g. metal bedpans
  - Actual weapons brought into workplace
  - Increased patient census and/or acuity
  - Insufficient staff

**Form for Reporting a Health and Safety Hazard to Manager**

TO: \_\_\_\_\_  
(your direct manager)

I am required by the *Occupational Health and Safety Act (OHSA)* to report to you any hazard(s) and any absence of or defect in equipment which may endanger workers.

The hazard(s) I am reporting is:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

ORIGINAL: **Manager** COPIES: **ONA Bargaining Unit President, JHSC ONA Rep, Self**

## APPENDIX I : Resources

### The Ontario Nurses' Association

The Ontario Nurses' Association (ONA) is dedicated to providing all members with the information and support they need in the important area of occupational health and safety.

Here is a list of what we offer:

- ONA provides support to each Bargaining Unit's occupational HSR/ONA JHSC member when there has been a perceived violation of the *Occupational Health and Safety Act*. Through Local activities, the Bargaining Unit is the primary provider of occupational health and safety services to membership. That includes ensuring there is a functioning JHSC at the Bargaining Unit level when required by the Act. Resource support is provided to Bargaining Units by the Labour Relations Officers (LROs) of ONA's four district service teams (North, South, West and East).
- Each district service team has a LRO with the primary responsibility of being an occupational health and safety resource in ONA's five regions. There are also LROs in all five regions whose primary responsibility is LTD. However, that does not mean occupational health and safety is the sole function of that LRO. The district service teams deliver occupational health and safety services through a variety of means.
- Additionally at the provincial level, support is provided to staff and membership by the Vice-President who holds the portfolio for occupational health and safety, LROs who specialize in occupational health and safety, Workers' Compensation matters, and Professional Practice Specialists.
- ONA's website ([www.ona.org](http://www.ona.org)) contains useful information, resources and tools pertaining to many health and safety issues.

## ONA Provincial Office – Toronto

85 Grenville Street  
 Toronto, ON M5S 3A2  
 Phone: 416-964-8833  
 Fax: (416) 964-8864  
 Website: [www.ona.org](http://www.ona.org)

## ONA Regional Offices

Please note that if your call/fax is local to the regional office, you should use the local dialing option where possible.

Phone: 1-800-387-5580 (toll free)	
Fax: 1-866-964-8864 (toll free)	
<b>Hamilton</b>	55 Head Street, Suite 306, Dundas, ON L9H 3H8
<b>Kingston</b>	4 Cataraqui Street, Suite 201, Kingston, ON K7K 1Z7
<b>London</b>	1069 Wellington Road S, Suite 109 London, ON N6E 2H6
<b>Orillia</b>	210 Memorial Avenue, Unit 126A, Orillia, ON L3V 7V1
<b>Ottawa</b>	1400 Clyde Avenue, Suite 211 Nepean, ON K2G 3J2
<b>Sudbury</b>	128 Pine Street, Suite 201, Sudbury, ON P3C 1X3
<b>Thunder Bay</b>	Woodgate Office Centre 1139 Alloy Drive, Suite 200, Thunder Bay, ON P7B 6M8
<b>Timmins</b>	Canadian Mental Health Association Building 330 Second Avenue, Suite 203, Timmins, ON P4N 8A4
<b>Windsor</b>	3155 Howard Avenue, Suite 220, Windsor, ON N8X 3Y9
<b>Port Hope</b>	45 Henderson Street, Unit 2, Port Hope, ON L1A 0C6

## Workers Health and Safety Centre

The WHSC is one of the Safe Workplace Associations funded by the WSIB. Based in Ontario, this worker-driven organization's mandate is to effectively develop and provide occupational health and safety leadership, training and education programs and information services that meet workers' needs and are consistent with labour's principles. Its mandate also includes promoting activities that involve workers in health and safety matters and improve working conditions and worker well-being. Its website also contains information on training programs and a service allowing you to ask health and safety-related questions.

## WHSC Head Office

675 Cochrane Dr., Suite 710, East Tower  
 Markham, ON L3R 0B8  
 Tel: 416-441-1939  
 Toll free: 1-888-869-7950  
 Website: [www.whsc.on.ca](http://www.whsc.on.ca)

WHSC Regional Offices can be reached toll free 1-888-869-7950. Their regional office locations are also on its website.

## **Public Services Health and Safety Association**

The Public Services Health and Safety Association (PSHSA) is a not-for-profit organization, designated as a Safe Workplace Association (SWA) under the *Workplace Safety and Insurance Act* (S.O. 1997) funded by the Ministry of Labour. The mandate of PSHSA is to educate and guide their health care and community services clients to proactively adopt occupational health and safety best practices and strategies that will prevent workplace fatalities, injuries, and illnesses.

### **PSHSA Head Office**

4950 Yonge Street, Suite 1800  
 Toronto, ON M2N 6K1  
 Tel: (416) 250-2131  
 Toll free: 1-877-250-7444  
 Fax: (416) 250-7484  
 Website: [www.pshsa.ca](http://www.pshsa.ca)

## **Occupational Health Clinics for Ontario Workers**

The Occupational Health Clinic for Ontario Workers (OHCOW) is a non-profit organization. It is one of the Health and Safety Associations funded by the Ministry of Labour/Workplace Safety and Insurance Board.

The mission of OHCOW is to prevent occupational illnesses and injury, and to promote the highest degree of physical, mental and social well-being of all workers.

OHCOW strives to accomplish this through the identification of workplace factors which are detrimental to the health and well-being of all workers, through the distribution of excellent occupational health, hygiene, and ergonomic information to



increase knowledge among workers, employers and the general public; and through the provision of services designed to produce changes to improve workplaces and the health of workers.

Staffed by an inter-disciplinary team of doctors, nurses, hygienists, ergonomists, researchers and administrators, each OHCOW clinic provides comprehensive occupational health services and information in five areas:

- An inquiry service to answer work-related health and safety questions.
- Medical diagnostic services for workers who may have work-related health problems.
- Group prevention service for workplace health and safety committees and groups of workers.
- Outreach and education to increase awareness of health and safety issues, and promote prevention strategies.
- Research services to investigate and report on illnesses and injuries.

*\* The clinic's services are free of charge to workplace parties.*

### **OHCOW Provincial Office**

1090 Don Mills Road, Suite 606  
 Toronto, ON, M3C 3R6  
 Tel: (416) 510-8713  
 Fax: (416) 443-9132  
 E-mail: [info@ohcow.on.ca](mailto:info@ohcow.on.ca)  
 Website: [www.ohcow.on.ca](http://www.ohcow.on.ca) <http://ohcow.on.ca/>

All clinics can be reached toll free at 1-877-817-0336. All locations of their regional offices are listed on their website.

### **Canadian Centre for Occupational Health and Safety**

The CCOHS promotes a safe and healthy working environment by providing information and advice about occupational health and safety.

CCOHS fulfills its mandate to promote workplace health and safety and encourage attitudes and methods that will lead to improved worker physical and mental health, through a wide range of products and services. These products and services are designed in cooperation with national and international occupational health and safety organizations with an emphasis on preventing illnesses, injuries, and fatalities. They provide a variety of both public service initiatives at no charge to the user, such as OSH Answers, the person-to-person Inquiry Service, the electronic

newsletter, and public presentations. Services for specialty resources provided on a cost recovery basis include database subscriptions, manuals, and training programs.

### **CCOHS Head Office**

135 Hunter Street East  
Hamilton, ON L8N 1M5  
Tel: (905) 572-2981  
Fax: (905) 572-2206  
Toll-free: [1-800-668-4284](tel:1-800-668-4284)  
Website: [www.ccohs.ca](http://www.ccohs.ca) <http://www.ccohs.ca/>

### **Inquiries and Client Services**

The CCOHS Inquiries and Client Services team is dedicated to answering any questions you may have – whether it be a health or safety concern about the work you do, or about our many products and services. This person-to-person service is offered via web, phone or fax.

Tel: (905) 570-8094  
Toll-free: 1-800-668-4284  
Fax: (905) 572-4500  
Website: [www.ccohs.ca/ccohs/inq.html](http://www.ccohs.ca/ccohs/inq.html)

### **The National Institute for Occupational Safety and Health**

NIOSH is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness. NIOSH is part of the Centers for Disease Control and Prevention (CDC) in the Department of Health and Human Services.

NIOSH is in the U.S. Department of Health and Human Services and is an agency established to help assure safe and healthful working conditions for working men and women by providing research, information, education, and training in the field of occupational safety and health.

NIOSH provides national and world leadership to prevent work-related illness, injury, disability, and death by gathering information, conducting scientific research, and translating the knowledge gained into products and services. NIOSH's mission is critical to the health and safety of every American worker.

The NIOSH website provides access to the full range of NIOSH information and publications.

### **CDC/NIOSH Contact Information**

1-800-CDC-INFO (1-800-232-4636)

Email: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)

Website: [www.cdc.gov](http://www.cdc.gov) <http://www.cdc.gov/>

1-888-232-6348 TTY

### **Ontario Ministry of Labour, Immigration, Training and Skills Development**

Established in 1919 to develop and enforce labour legislation, the mission of the Ministry of Labour, Immigration, Training and Skills Development (MLITSD) is to advance safe, fair and harmonious workplace practices that are essential to the social and economic well-being of the people of Ontario. As of April 2012, prevention resources have been moved from the WSIB to a newly formed Chief Prevention Office in the Ministry of Labour.

Through the Ministry's key areas of occupational health and safety, employment rights and responsibilities, labour relations and internal administration, the Ministry's mandate is to set, communicate and enforce workplace standards while encouraging greater workplace self-reliance. A range of specialized agencies, boards and commissions assist the Ministry in its work.

### **MLITSD Main Office – Toronto**

#### **Occupational Health and Safety Branch**

400 University Avenue, 14<sup>th</sup> Floor

Toronto, ON M7A 1T7

Toll-free: 1-877-202-0008

Fax: (905) 577-1316

Website: [www.labour.gov.on.ca/](http://www.labour.gov.on.ca/)

### **MLITSD Regional Offices**

To make a complaint or to report fatalities and critical injuries during day-time hours, call 1-877-202-0008 or send an online complaint to [www.ontario.ca/page/filing-workplace-health-and-safety-complaint](http://www.ontario.ca/page/filing-workplace-health-and-safety-complaint)

### **Occupational Health and Safety Contact Centre**

To report critical injuries, fatalities, work refusals or other concerns, please call the toll-free number at 1-877-202-0008. You can also email your questions to [webohs@ontario.ca](mailto:webohs@ontario.ca).

## **BIBLIOGRAPHY**

Bird, F.E., (1980). Mine safety and loss control: A management guide. Institute Press: Loganville, Georgia.

Braun, B. I., Hafiz, H., Singh, S., & Khan, M. M. (2021). Health Care Worker Violent Deaths in the Workplace: A Summary of Cases From the National Violent Death Reporting System. *Workplace health & safety*, 69(9), 435–441.  
<https://doi.org/10.1177/21650799211003824>

Bujna, E., Casselman, N., Devitt, R., Loverock, F., & Wardrope, S. (2015). Leadership engagement and workplace violence prevention: The collaboration between a large community hospital and its unions. *Healthcare Quarterly*, 18(2), 18-24.

Büssing A, Höge T. (2004). Aggression and violence against home care workers. *Journal Of Occupational Health Psychology*, 9(3):206-19.

Byon, H. D., Sagherian, K., Kim, Y., Lipscomb, J., Crandall, M., & Steege, L. (2021). Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic. *Workplace health & safety*, 21650799211031233. Advance online publication. <https://doi.org/10.1177/21650799211031233>

Canadian Centre for Occupational Health and Safety. (n.d) Violence in the workplace. Retrieved June 25, 2019 from [www.ccohs.ca/oshanswers/psychosocial/violence.html](http://www.ccohs.ca/oshanswers/psychosocial/violence.html).

Canadian Nursing Advisory Committee. (2002). Our health, our future: Creating quality workplaces for Canadian nurses. Ottawa, ON: Advisory Committee on Health Human Resources. Retrieved August 7, 2008, from: [http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2002-cnac-cccsi-final/2002-cnac-cccsi-final-eng.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-cnac-cccsi-final/2002-cnac-cccsi-final-eng.pdf)

Clancy, N. (2015, March 3) Nurse attacks: are bruises and black eyes the new face of B.C. health care. *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/british-columbia/nurse-attacks-are-bruises-and-black-eyes-the-new-face-of-b-c-health-care-1.2980754>

College of Nurses of Ontario. (2009) *Restraints* [Practice Standard], Toronto: College of Nurses of Ontario. Retrieved from [www.cno.org/docs/prac/41043\\_Restraints.pdf](http://www.cno.org/docs/prac/41043_Restraints.pdf).

Speroni K.G, Fitch, T., Dawson, E., Dugan, L., Atherton, M. (2014) Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *J Emerg Nurs* 40(3):218- 28; doi: 10.1016/j.jen.2013.05.014.

Cook, J. K., Green, M., Topp, R.V. (2001). Exploring the impact of physician verbal abuse on perioperative nurses. *AORN Journal*, 74(3):317-20, 322-7, 329-31.

Criminal Injuries Compensation Board (CICB). Retrieved from: [www.cicb.gov.on.ca/en/about.htm](http://www.cicb.gov.on.ca/en/about.htm).

de Léséleuc, S (2007). *Criminal victimization in the workplace, 2004*. Canadian Centre for Justice Statistics profile series, no. 013. Ottawa: Statistics Canada. [http://epe.lac-bac.gc.ca/100/200/301/statcan/cdn\\_centre\\_justice-85F0033-e/013/85F0033MIE2007013.pdf](http://epe.lac-bac.gc.ca/100/200/301/statcan/cdn_centre_justice-85F0033-e/013/85F0033MIE2007013.pdf)

Edward, K.L., Ousey, K., Warelow, P., & Lui, S. (2014) Nursing and aggression in the workplace: A systemic review *Br J Nurs*. 9;23(12):653-4, 656-9. doi:10.12968/bjon.2014.23.12.653.

Edward, Stephenson, Ousey, Lui, Warelow & Giandinoto, 2016. A systematic review and meta- analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff.

Gillespie, G.L., Gates, D.M., Kowalenko, T., Bresler, S., & Succop, P. (2014) Implementation of a comprehensive intervention to reduce physical assaults and threats in the emergency department. *Journal of Emergency Nursing*, Advance online publication doi: 10.1016/j.jen.2014.01.003.

International Council of Nurses. (2001). *Violence: a world-wide epidemic*. [Fact Sheet].

International Council of Nurses. (2009). *Nursing Matters Violence: A worldwide epidemic*

Jaffe, P. [Presenter] (2008, April 2) *Missed opportunities: From awareness to skill building in addressing domestic and workplace violence against women*. [PowerPoint slides]. Presented at Workplace Violence Prevention: The New Benchmark for Due Diligence, OSACH Workplace Violence Prevention Video/Teleconference.

May, D. D., Grubbs, L. M. (2002). The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center. *Journal of Emergency Nursing*, 28(1), 11-17.

National Institute for Occupational Safety and Health. (2002). *Violence: occupational hazards in hospitals*. Cincinnati, OH: Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Retrieved from [www.cdc.gov/niosh/pdfs/2002-101.pdf](http://www.cdc.gov/niosh/pdfs/2002-101.pdf).

O'Brien-Pallas, L.L., Whitehead, J. (2005). *Canadian survey of nurses from three occupational groups*. Ottawa, Ont: Nursing Study Sector Corporation. Retrieved from [https://cna-aiic.ca/~media/cna/page-content/pdf-fr/canadian\\_nurses\\_survey\\_3occupational\\_groups\\_e.pdf](https://cna-aiic.ca/~media/cna/page-content/pdf-fr/canadian_nurses_survey_3occupational_groups_e.pdf)

Occupational Health Clinics for Ontario Workers (OHCOW) "Mental Injury Toolkit"  
<http://www.ohcow.on.ca/mental-injury-toolkit.html>

Ontario Nurses' Association. (2012, Dec.) Workplace violence. *ONA Dialogue: The e-newsletter for leaders of the Ontario Nurses' Association*, 5:1-5.

Ontario Nurses' Association. (2012) Survey Copenhagen Psychosocial Questionnaire (COPSOQ) of ONA health and safety activists.

Ontario Safety Association for Community & Healthcare 2006, *A guide to the development of a workplace violence program: Implementing the program in your organization*, Toronto, Ontario, Canada.

Pompeii, L. A., Schoenfisch, A. L., Lipscomb, H. J., Dement, J. M., Smith, C. D. and Upadhyaya, M. (2015), Physical assault, physical threat, and verbal abuse perpetrated against hospital workers by patients or visitors in six U.S. hospitals. *Am. J. Ind. Med.*, 58: 1194–1204. doi: 10.1002/ajim.22489).

Rosen J. (2013) Overview and summary: Patient and visitor violence: what do we know? What can we do? *Online J Issues Nurs*, 18(1).  
doi:10.3912/OJIN.Vol18No01ManOS.

Rutherford, A., Rissel, C. (2004) A survey of workplace bullying in a health sector organization *Australian Health Review* 30;28(1):65-72.

Sofield, L., Salmond S.W. (2003). Workplace violence. A focus on verbal abuse and intent to leave the organization *Orthopaedic Nursing*, 22(4):274-83.

Spector PE, Zhou ZE, Che XX. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *Int J Nurs Stud* 51(1):72-84. doi: 10.1016/j.ijnurstu.2013.01.010

Staff Abuse: Prevention and Management Initiative. (2000). *Abuse in the workplace: a program development guide for health care organizations*. [Alta.]: Staff Abuse: Prevention and Management Initiative.

Toronto East General Hospital. (2008). *Preventing workplace violence: One hospital's story* [Powerpoint slide] Preventing workplace violence: Enabling a culture of respect, Toronto: Ont: Ontario Hospital Association.

United States. (2004). *Guidelines for preventing workplace violence for health care & social service workers*. Washington, D.C.: U.S. Dept. of Labor, Occupational

Safety and Health Administration. Retrieved from  
<https://www.osha.gov/Publications/osh3148.pdf>

Vellani, K.H.; The International Association for Healthcare Security & Safety (IAHSS). (2017, April 25 6) *2017 Healthcare Crime Survey*. Retrieved from:  
<http://www.iahss.org/?foundationresearch>  
[https://cdn.ymaws.com/www.iahss.org/resource/collection/48907176-3B11-4B24-A7C0-FF756143C7DE/2017\\_Crime\\_Survey\\_-\\_IAHSS\\_Foundation.pdf](https://cdn.ymaws.com/www.iahss.org/resource/collection/48907176-3B11-4B24-A7C0-FF756143C7DE/2017_Crime_Survey_-_IAHSS_Foundation.pdf)

Workers' Compensation Board of British Columbia. (2000). *Preventing violence in health care: five steps to an effective program*. [Richmond,]: Workers' Compensation Board of British Columbia. Retrieved from:  
[https://www.google.com/search?q=Workers%27+Compensation+Board+of+British+Columbia.+\(2000\).+Preventing+violence+in+health+care%3A+five+steps+to+an+effective+program.&oq=Workers%27+Compensation+Board+of+British+Columbia.+\(2000\).+Preventing+violence+in+health+care%3A+five+steps+to+an+effective+program.&aqs=chrome..69i57j69i59.1799j0j7&sourceid=chrome&ie=UTF-8](https://www.google.com/search?q=Workers%27+Compensation+Board+of+British+Columbia.+(2000).+Preventing+violence+in+health+care%3A+five+steps+to+an+effective+program.&oq=Workers%27+Compensation+Board+of+British+Columbia.+(2000).+Preventing+violence+in+health+care%3A+five+steps+to+an+effective+program.&aqs=chrome..69i57j69i59.1799j0j7&sourceid=chrome&ie=UTF-8)

Workplace Safety and Insurance Board (WSIB) EIW Claim Cost Analysis Schema, June 2018 and 2017 data snapshots.