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

Position Statement:

Violence Against Nurses:
'Zero Tolerance' For Violence Against Nurses and Nursing Students

The Registered Nurses' Association of Ontario (RNAO) takes a 'Zero Tolerance' approach to violence in the workplace. RNAO believes that ***all nurses have the right to practice in a supportive environment where workplace violence is not tolerated.***

Employers have a responsibility to implement policies, procedures and practices that promote safety and the well-being of nurses. Governments have a responsibility to fund and support work environments that promote safety and well-being.

Workplace violence frequently occurs in health-care environments.[1] Although the definition of violence varies depending on practice settings or situations, there is agreement that violence in the workplace is detrimental to the health and well-being of nurses and to the provision of quality nursing care.[2] Workplaces include hospitals and long-term care facilities, as well as practice settings in the community such as primary care sites, outreach services, educational institutions, and clients' homes.

Definition of Workplace Violence
This policy statement defines workplace violence as ***'an incident of aggression that is physical, sexual, verbal, emotional or psychological that occurs when nurses are abused, threatened or assaulted in circumstances related to their work'***.[3]

It is estimated that 50 per cent of health-care workers will be physically assaulted during their professional careers, [4] and nurses are three times more likely to experience violence than any other professional group.[5] Given that nurses constitute 58.3 per cent [6] of Ontario's health-care workers, the impact of workplace violence on nursing and the delivery of nursing care is significant. Nurses experience emotional distress and physical injuries – and in more serious instances, permanent disability or death – as a result of workplace violence.[7] In one study, the cost of workplace violence against nurses, including absence from work,[8] emotional distress, and medical expense, was estimated at about $35,000 per assault-related injury.[9]

Nurses working in all sectors of health care are at risk for violence. [10] [11] [12] [13] Findings from the 2005 National Survey of the Work and Health of Nurses showed that in Ontario 28.4 percent of respondents had been physically assaulted by a patient in the previous twelve months and 2 per cent had been physically assaulted by someone other that a patient. [14] In the same survey, the percentage of Ontario respondents who reported they had experienced emotional

abuse at work, over the past 12 months was: from a patient, 44.9 per cent; from a visitor, 16.9 per cent; from a physician, 8.7 per cent; from a nurse co-worker, 10.3 per cent; and from someone else, 9.0 per cent. [15]

Nursing students have similar experiences to registered staff including experiencing horizontal violence.[16] This can influence a student's decision to remain in the profession. Also, there is concern that students may begin to assimilate this conduct into their practice, perpetuating the behaviour.[17] Faculty are also known to experience uncivil encounters with students. These are concerning as these experiences have caused some to leave teaching. This leads to a shortage of educators, and aggravates the shortage of nurses by reducing the ability of programs to take in students.[18]

Recruitment and retention in the Ontario nursing workforce is a major concern for government and nursing organizations.[19] With 21.3 per cent of the nursing workforce eligible to retire as of 2005, issues of retention and recruitment are even more pressing.[20] Violence in the workplace directly impacts the number of individuals who enter or remain in the nursing profession.[21] [22] [23]

Contributing Factors

Violence toward nurses originates from multiple sources and risks are multifaceted. It is important to take a broad approach, examining societal, workplace, and individual factors, and recognizing the dynamic relationship between them.

Social Factors

Acts of direct violence against individuals may be most usefully understood within the context of structural and cultural violence. Structural violence refers to any constraint on human potential due to economic and political structures. Structural inequalities in access to resources and political power create inequitable access to opportunities.[24] A lack of social justice may be equated with structural violence. Cultural violence is any aspect of a culture that can be used to legitimize violence in its direct or structural forms.[25] For example, elements of patriarchal cultures can support the idea that women are less valuable than men, so striking them or paying them less than their male counterparts is somehow acceptable. At the individual level, structural violence, and the cultural violence that makes it possible, is manifested in various forms of direct or overt violence. These include:

- Chronic oppression experienced as unremitting poverty and social exclusion may be accompanied by substance abuse, mental illness, and violent behaviour against oneself and others, including health professionals.[26] [27] [28]
- Nursing continues to be a female-dominated profession, and societal attitudes continue to devalue and sexualize nursing. [29] [30] As a result, violence against nurses can be considered part of the continuum of violence against women.
- Nurses who are disabled, racialized, immigrants, gay, lesbian, bisexual, or transgender experience discrimination from patients, clients, and colleagues.

It is therefore likely that they could face increased violence in the workplace.[31]

Workplace Factors

A number of factors contribute to violence in the health-care workplace depending on practice setting. Some of these include:[32]

- An underlying assumption that as a nurse, violence is 'part of the job' and must be 'tolerated'.[33]
- Inadequate staffing and resources, resulting in long wait times to access care.
- Health-care system restructuring, changing technology, and increased public expectations contribute to challenges in meeting actual and perceived needs of the public.[34] [35]
- Poor environmental design increasing the likelihood of nurses being isolated with violent clients.
- Inadequate security measures with respect to staffing or response procedures.
- Inadequate training for staff on responding to potentially violent situations.
- Inadequate expectations of how the health-care team will interact with each other.
- Inadequate policies for preventing and managing violent incidents.
- Inadequate supports for nurses who work alone - for instance, community health nurses.
- Under-reporting of violence which limits both knowledge of scope of issue and corrective action.

Forms of Violence Against Nurses

Clients and families are involved in the majority of incidents of violence toward nurses.[36] Situations and individual risk factors most likely to elicit violent or abusive behaviour toward nurses include:

- Emotionally-charged practice environments that have the potential for unpredictable outcomes, such as clients' homes, emergency departments or intensive care units.
- Clients and family members who may be struggling to cope with stress, frustration, and/or grief.
- Clients and family members who have mental health issues and may have a history of violent behaviour.
- Clients and family members whose cognition is impaired, such as those who experience delirium, dementia, or brain injury/disease.
- Clients and family members who are under the influence of behaviour-altering substances.

Physicians have been cited as the major source of verbal abuse that nurses are subjected to on almost a daily basis.[37] [38] [39] [40] This form of abuse often arises out of power differentials between physicians and nurses. These power differentials are related to two main factors:

- The lower status associated with the female-dominated nursing profession as compared to the historically male medical profession.
- The disproportionately higher value that society has granted to the medical profession compared to the nursing profession.

Nurse to nurse, nurse to nursing student and nursing student to nurse violence is often ignored or downplayed by both nurses and institutions. This form of violence is often referred to as 'bullying' or 'interpersonal conflict'.[41] Nurses experience this form of violence as a routine part of their work life. While explanations for this vary, they include:

- As a female-dominated profession, nurses, like other oppressed groups, often feel a lack of control. Attempts to gain control may take the form of intimidation or abuse of nurses by nurses.[42]
- Racism, sexism, and other forms of discrimination among nurses are expressed through verbal abuse and put-downs from nursing colleagues. [43]
- Stress caused by higher patient acuity, nursing shortages, and organizational and staffing changes leads to 'burn out' and creates a propensity for nurses to abuse other nurses.[44]

Recommendations

RNAO calls for the development and implementation of specific strategies to prevent and stop violence against nurses in the workplace. Recommendations from societal, organizational, and individual perspectives include:

Societal

- Adequate funding across all health-care sectors to ensure optimal client care and safe working environments.
- Support for intermediate multi-sectoral services so that people can be supported in recovery from mental illness and addictions. These include health-care services, supportive housing, and educational and employment opportunities.
- Multi-sectoral strategies to address root causes of material deprivation and social exclusion. Decreasing poverty, wealth inequalities, and social exclusion will improve health and strengthen communities.
- Legislation for whistle-blowing protection (prohibit retaliation or threats of retaliation) for anyone who reports incidents of violence.

Workplace

- A 'Zero Tolerance to Violence' policy.
- A mechanism to disseminate the policy to all staff, volunteers, clients, family members, and visitors.
- Adequate staffing to enable nurses and other health professionals to deliver timely care.[45]
- An inclusive and respectful practice environment where there is collaboration among team members;
- A workplace violence committee, which includes nurses, to develop strategies for controlling and reporting violent behaviour;
- A violence prevention/management education and training program for all staff, including discussion about accountability and respect for others.
- A system to identify and flag situations that could create a potential for violence.
- An immediate response plan.

- A collaborative agreement with local law enforcement agencies for immediate response in the event of an actual or potentially violent situation.
- A Critical Incident Debriefing Program that includes peer support.
- An Employee Assistance Program (EAP), counselling, security, and other support staff as required.
- Support and encouragement for nurses to report incidents of workplace violence and to prosecute individuals who commit violent acts.

- A mechanism to track and review incidents or potential incidents of violence.

Specific to Institutions
All recommendations under *organizations* plus:

- Workplace environments that optimize safety. For example: monitoring systems, providing escorts to parking lots at night.
- Emergency signalling and alarm systems.

Specific to Community Settings
All recommendations under *organizations* plus:

- Communication devices such as cell phones and panic buttons.
- Daily itineraries identifying clients' names, addresses, telephone numbers, and approximate times of visits.

Universities and Colleges

- Course content that incorporates best practice for violence prevention and conflict resolution in all nursing, medical school and other health-care professionals' educational curricula. This should include communication strategies that promote respect and understanding for each discipline's similarities and differences.

Individual

- All individuals have the responsibility to respect the rights of others and not to discriminate based on disability, race, ethnicity, sex, sexual orientation, or profession.

Conclusion

RNAO takes a 'Zero Tolerance' approach to workplace violence. It is important to ensure safe practice settings for all health-care providers, and imperative that violence is addressed from a societal, organizational, and individual level.

Revised September 2008

References

[1] Erikson, L. & Williams-Evans, A. (2000). Research: attitudes of emergency nurses regarding patient assault. *Journal of Emergency Nursing, 26*(3), 210-215.
[2] Hoel, H; Sparks, K.; Cooper, C. (2000). The cost of violence and stress at work and the benefits of a violence and stress-free working environment. *University of Manchester Institute of Science and Technology*. Retrieved October 24 from: http://www.ilo.org/public/english/protection/safework/whpwb/econo/costs.pdf
[3]International Labour Office, International Council of Nurses, World Health Organization,

Public Services International. (2002). Framework guidelines for addressing workplace violence in the health sector. Geneva, International Labour Office. Retrieved October 5, 2006 from: http://www.icn.ch/proof3b.screen.pdf

[4] Umiker, W. (1997). Workplace violence: the responsibility of employers and supervisors. *Health Care Supervisor* 19(1), 29-41.

[5] International Council of Nurses. "International Nurses'Day- IND Kit 2001," updated February 12, 2003.

[6] Ontario Regulators for Access, Access to Ontario's Professions retrieved October 16, 2006 from: http://www.regulators4access.ca/html/introreg.htm

[7] Lewis Lanza, M., Demaio, J. Benedict, M.A. (2005). Patient assault support group: achieving educational objectives. *Issues In Mental Health Nursing, 26*, 643-60.

[8] Nursing Sector Study Corporation. (2005). Workforce Trends of Registered Nurses in Canada.

[9] Lanza, M. Demaio, J. & Benedict, M. (2005). Patient assault support group: achieving educational objectives. *Issues in Mental Health Nursing, 26*, 643-660.

[10] Hesketh, K., Duncan, S., Estabrooks, C. Reimer, M, Giovannetti, P. Hyndman, K., et al. (2003). Workplace violence in Alberta and British Columbia hospitals. *Health Policy, 63*, 311-321.

[11] Lipscome, J. & Borwegan, B. (2000). Healthcare workers. In B.Levy & D.Wegman (Eds.), *Occupational health recognizing and preventing work-related disease and injury* (4th ed.). pp. 767-778. Philadelpha: Lippincott, Williams & Wilkins.

[12] Duhart, D. (2001). *Violence in the workplace, 1993-99* (No. December 2001, NCJ190076). Washington, DC: U.S. Department of justice, Office of Justice Programs.

[13] McCall, B., & Horwitz, I. (2004). Workplace violence in Oregon: an analysis using workers' compensation claims from 1990-1997. *Journal of Occupational and Environmental Medicine, 46*(4), 357-366.

[14] Statistics Canada (2006). Findings from the 2005 National Survey of the Work and Health of Nurses. Author

[15] ibid.

[16] Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing, 21*(3), 177-178.

[17] Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43*(4), 395-401.

[18] Luparell, S. (2007). The effects of student incivility on nursing faculty. *Journal of Nursing Education*, pp 15-19.

[19] Canadian health Services Research Foundation. (2006). What's Ailing Our Nurses? A Discussion of the Major Issues Affecting Nursing Human Resources in Canada. www.chsrf.ca/www.fcrss.ca

[20] Canadian Institute for Health Information (2006) *Workforce Trends of Registered Nurses in Canada, 2005*, Ottawa, p. 19.

[21] International Labour Office, International Council of Nurses, World Health Organization, Public Services International. (2002). Framework guidelines for addressing workplace violence in the health sector. Geneva, International Labour Office. Retrieved October 5, 2006 from: http://www.icn.ch/proof3b.screen.pdf

[22] Rosenstein, A. (2002). Nurse-physician relationships: impact on nurse satisfaction and retention. *American Journal of Nursing 102*(6), 26-34.

[23] Miller, P. (2001). Nurse-physician collaboration in an intensive care unit. *American Journal of Critical Care, 10*(5), 341-50.

[24] Galtung, J. (1969) Violence, Peace, and Peace Research. *Journal of Peace Research*. Vol. 6. No. 3, 167-191.

[25] Galtung, J. (1999). Cultural Violence. *Journal of Peace Research*. Vol. 27. No. 3, 291-305.

[26] Marmot, M. & Wilkinson, R. eds. (1999). *Social Determinants of Health*. Oxford: Oxford University Press.

[27] Holness, D., Somerville, S., Kosny, A., Gadeski, J., Mastandrea, J. & Sinclair, G. (2004). Workplace Health and Safety Concerns in Service Organizations in the Inner City. *Journal of Urban Health: Bulletin of the New York Academy of Medicine.* Vol. 81., No. 3. 489-497.

[28] Schulte, J., Nolt, B., Williams, R., Spinks, C. & Hellsten, J. (1998). Violence and Threats of Violence Experienced by Public Health Field-Workers. *Journal of the American Medical Association.* Vol. 280. No. 5, 439-442.

[29] Kalish, B, Kalish, P., & McHugh, M. (1982). The Nurse as a Sex Object in Motion Pictures, 1930 to 1980. *Research in Nursing and Health*. Vol. 5. No. 3, 147-154.

[30]For more recent examples, please see the Center for Nursing Advocacy on Naughty Nurse Stereotype. Retrieved November 6, 2006 from:

http://www.nursingadvoccy.org/faq/naughty_nurse.html

[31] Summers, A. (2006). Focusing on human rights and equity- cultural research project 2003-2004 in *Ontario Nurses' Association, Vision 33*(1), 25-33.

[32] International Labour Office, International Council of Nurses, World Health Organization, & Public Services International. (2002). Framework guidelines for addressing workplace violence in the health sector. *Joint Programme on Workplace Violence in the Health Sector.*

[33] Gates, D. & Kroeger, D, .2002.

[34] Morrison, L. (1999). Abuse of Emergency Department Workers: An Inherent Career Risk or a Barometer of the Evolving Health Care System? *Canadian Medical Association Journal*. Vol. 161. No. 10, 1262-1263.

[35] May, D. & Grubbs, L. (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.* Vol 28. No. 1, 11-17.

[36] Lipscomb, J., Silverstein, B. Slavin, T. Cody, E. & Jenkins, L. (2002). Perspectives on legal strategies to prevent workplace violence. *Journal of Law, Medicine and Ethics, 30*(3 Suppl), 166-172.

[37] Manderino, M. (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing, 13*(1), 48-55.

[38]Henderson, A. (2003). Nurses and workplace violence: nurses' experiences of verbal and physical abuse. *Canadian Journal of Nursing Leadership*, 16(4), 82-98.

[39] Canadian Health Services Research Foundation. (2006). What's ailing our nurses? A discussion of the major issues affecting nursing human resources in Canada. Retrieved October 12, 2006 from: www.chsrf.ca

[40] Oweis, A. & Diabat, K. (2005). Jordanian nurse perception of physicians' verbal abuse: findings from a questionnaire survey. *International Journal of Nursing Studies 42*, 881-888.

[41] Hockley, C. (2000). The language used when reporting inter-female violence among nurses in the workplace. *Collegian, 7*(4), 24-29.

[42] Stevens, S. (2002). Nursing workforce retention: challenging a bullying culture. *Health Affairs, 21*(5), 189-193.

[43] Das Gupta, T. (2003). Racism in nursing. Retrieved November 6, 2006 from: http://www.ona.org/pdflib/dasgupta.pdf

[44] Rowe, M. & Sherlock, H. (2005). Stress and verbal abuse in nursing: do burned out nurses eat their young. *Journal of Nursing Management 13*, 242-248.

[45] Registered Nurses' Association of Ontario. (due for release December 2006). Developing and sustaining effective staffing and workload practices. Healthy Work Environments. Best Practice Guidelines. Retrieved November 14, 2006 from: www.rnao.org.