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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1550)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome, everybody, to meeting number 151 of the Standing Committee on Health.

Today we're going to continue our most interesting study on violence faced by health care workers, and I welcome all our guests.

As our guests, as individuals by video conference from Emeryville, Ontario, we have James Brophy, adjunct faculty of the sociology department, University of Windsor; and Margaret Keith, adjunct faculty of the sociology department, University of Windsor.

From the Alzheimer Society of Canada, by video conference from Toronto we have Mary Schulz, director, information, support services and education.

From the British Columbia Nurses' Union, by video conference from Burnaby, British Columbia, we have Adriane Gear, executive councillor, occupation health and safety; and Moninder Singh, director, occupation health and safety.

Here in person, from the Public Services Health and Safety Association is Henrietta Van hulle, vice-president, client outreach.

I welcome you all. Each group has a 10-minute opening statement and we'll start with, as individuals, James Brophy and Margaret Keith.

Prof. James Brophy (Adjunct Assistant Professor, Sociology Department, University of Windsor, As an Individual): First of all, we want to thank and commend the committee for looking at these very important issues, both human rights and occupational health issues, and also to thank you for asking us to testify.

I am Dr. James Brophy, and this is my partner, Dr. Margaret Keith. We both have Ph.D.s in occupational health from the University of Stirling in the U.K., where we hold appointments as visiting researchers.

We have recently published two studies. The first one focused primarily on violence against hospital staff, and the second on violence against long-term care staff.

I want to describe briefly how our research was carried out. Both studies were collaborative undertakings initiated by the Ontario Council of Hospital Unions affiliated with the Canadian Union of Public Employees. OCHU/CUPE has been very troubled by the pervasive threat to its members for several years.

Dr. Keith and I were asked to explore the issue and suggest potential solutions. As we were completing our study, OCHU/CUPE commissioned a poll to investigate the prevalence of violence perpetrated against hospital staff by patients. Almost 2,000 health care workers responded, providing results with a high level of statistical confidence.

According to the poll, 68% of registered practical nurses and personal support workers experienced at least one incident in the past year of physical violence; 20% experienced at least nine such assaults; 42% experienced sexual harassment and/or assault, 26% lost time from work due to workplace violence; and, despite the high number of incidents cited, only 57% said they had filed formal incident reports.

The research Dr. Keith and I conducted was qualitative rather than statistical. We designed our research to fully explore the issue of violence from the perspective of the health care workers themselves. We wanted to know exactly what they were experiencing, what they saw as the immediate and root causes of violence, and perhaps most importantly, what they believed needed to be done about it.

Both studies focused specifically on type 2 violence, in other words, violence against staff from a patient or family member. It is by far the most common type of workplace violence in the health care setting. Our first study was published a year and a half ago in the journal New Solutions, in an article entitled “Assaulted and Unheard: Violence Against Healthcare Staff.”

To gather first-hand experiential data, we talked to nurses and personal support workers, aides and porters, clericals, cleaners and dietary staff in communities across Ontario. This is what we heard. Violence is very widespread. Many of those we spoke with, especially those working in emergency departments, psychiatric units, forensics and dementia units told us that they regularly go into work fearing they will be assaulted.

They told us about their injuries, bruises, strains, scrapes, scratches, bites, torn ligaments, fractured bones, shattered faces, lost teeth and brain injuries inflicted by frustrated, angry, confused or intoxicated patients. Several said they suffered from ongoing emotional trauma that spills into their family lives. Most said that they are expected to quietly put up with aggression from patients and that it is just part of the job.

We learned that there are many modifiable risk factors for violence within the health care setting. In other words, prevention can be accomplished. Key among the recommended strategies was ensuring adequate staffing levels, a solution emphasized in much of the published scientific literature.

Engineering control, such as better building designs, can reduce risks.

Better communication, such as flagging aggressive patients and providing personal alarms, can convey protection for staff.

Increased high levels of security should be made available where needed. As well, wait times must be reduced to minimize anger, frustration and resulting aggression.

Also, patients need to be appropriately placed. For example, mental health patients should not be placed in acute care.

Zero tolerance policies must be enforced, including protection for those who are targeted because of race, gender or sexual orientation, and perpetrators of intentional violence against health care staff need to be held criminally responsible for their actions.

Dr. Keith will describe the second study and continue with some of our recommendations.

● (1555)

Prof. Margaret Keith (Adjunct Assistant Professor, Sociology Department, University of Windsor, As an Individual): Our second study was entitled “Breaking Point: Violence Against Long-Term Care Staff”. It was published in March of this year.

Like the problem of violence against hospital staff, violence against long-term care staff is well documented in the scientific literature, and we know it's widespread, perhaps even more so than for hospital staff.

In January of 2019, OCHU/CUPE commissioned another poll. Some 1,200 long-term care workers responded. Eighty-five per cent were women. Almost half self-identified as indigenous, racialized, recent immigrant or visible minority.

The results were really alarming. According to the poll, 89% of personal support workers and 88% of registered practical nurses experienced physical violence on the job. Sixty-two per cent of PSWs and 51% of nurses experienced it at least once a week. Sixty-five per cent of female staff have been sexually harassed, and 44% have been sexually assaulted. Sixty-nine per cent of those identifying as a visible minority indicated that they have experienced related abuse. Seventy-five per cent believe they are unable to provide adequate care due to their workload and low staffing levels, and 53% said they never file incident reports.

The research we carried out reveals the day-to-day reality behind these numbers. We spoke at length with dozens of long-term care staff in communities across Ontario. We heard such comments as this, “On a daily basis, I am hit, punched, spat at, sworn at, slapped, bitten. I've had hot coffee thrown at me. I've gone home with burns on my hands.” Or there's this one, “I put his pajamas on and I went to tie them. Then I saw his fist. Oh my God! Here it comes. Pow, right in the mouth. It cracked all my teeth and broke my nose.”

They described feelings of stress, burnout, anxiety, depression and fear. They talked about how sexist comments and sexual touching leaves them feeling hurt, angry and demoralized. One told us this: “He groped me when I was bathing him. It bothered me for a very long time, but I didn't dare say anything because I was worried about my job. I was a single mom and I had to work.” Another one said this: “It's degrading. There are times that you just sit down in your car and cry.”

Violence against long-term care staff can be prevented. This has been proven in Scandinavian countries. The conditions under which staff are working and residents are being cared for in Ontario breed aggression. We learned that the system is at a breaking point and that the staff are at their breaking point.

Our system is underfunded and understaffed. It has been widely privatized. Efficiencies and time studies have reduced the people in care to little more than objects on a production line. Care is rushed. There is little time for making emotional connections with residents, and this contributes to their frustration, fear and confusion, which they then direct towards their caregivers.

Several issues stood out for us as significant barriers to dealing with the problem of violence in both the hospital and the long-term care settings. There's a systemic under-reporting of violent incidents, resulting in an underestimation of their prevalence. Some study participants said they feel unsupported by their supervisors and even blamed for the assaults that they do report.

The culture of silence around the issue of violence is a major barrier to acknowledging its existence and consequently addressing it; however, although the public has been kept in the dark about this issue, it is not a problem that is unknown within the health care community.

We recently conducted a search of published literature on MEDLINE, an online database of medical and scientific research papers, and discovered an extensive compilation. Over 1,000 articles on this issue have appeared in peer-reviewed academic journals since 2000.

One of the more recent articles was a U.S. study published by Dr. James Phillips in the New England Journal of Medicine. The author concluded, “Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored.”

The solutions that the article put forward, and those outlined in many other studies, provide the same solutions offered by the health care workers we talked to, so we cannot say that we don't know how to protect staff from violence. Prevention strategies are well documented and have been for almost two decades, but in many cases the recommended solutions remain un-implemented. As a result, violence continues to harm health care workers.

Clearly, some will require significant financial investments, such as hospital redesign and increased staffing. Others simply require a change in approach. We have learned that violence prevention measures currently in place appear to be piecemeal and inconsistent from one facility to the next. Universal protections need to be legislated.

Ontario hospitals are operating with less per capita funding than the rest of Canada, and Canada falls below many of the OECD countries. Staffing levels are correspondingly lower. Patient wait times are elevated. As well, there is a shortage of mental health beds.

● (1600)

These failings contribute to violence and need to be addressed.

After studying this issue and talking to victims we feel strongly that we can't allow the problem of violence against health care workers to remain hidden from the public. In broader society we encourage victims of physical, verbal and sexual assault to speak out about it and to seek out support, but if those victims are health care workers they're told to be quiet about it. This repressive and unsupportive practice can add further insult to injury and further psychological harm to already traumatized victims.

We would contend that those who attempt to silence the victims of abuse are themselves complicit in the abuse. Legislated whistle-blower protection for staff would eliminate the fear the study participants expressed about being—

The Chair: Dr. Keith, I have to get you to finish up, please.

Ms. Margaret Keith: Prevention efforts need to address some of these underlying systemic causes. We can't ignore this issue just as we can't ignore domestic assault, discrimination, harassment or assault. Violence against health care staff is a human rights issue that we're all being challenged now to address.

Thank you.

The Chair: Thanks very much.

We'll now go to Mary Schulz from the Alzheimer Society of Canada, .

Ms. Mary Schulz (Director, Information, Support Services and Education, Alzheimer Society of Canada): Thank you, Mr. Chair, and good afternoon to members of the health committee.

The Alzheimer Society of Canada very much appreciates the opportunity to bring the perspective of how dementia can play a role in violent incidents between care providers and clients or residents. Violence or aggression between care providers and people with dementia in any setting is an important issue. We tend to normalize aggression in dementia, which can lead us to incorrectly think there's nothing we can do about it. Violence can be prevented, and today I will submit recommended strategies to do so.

We are privileged that dementia in Canada is now being addressed through our first national dementia strategy, and not a minute too soon. It's estimated that there are over 500,000 Canadians living with dementia, and this number is estimated to grow to nearly one million within the next 15 years.

As we discuss violence, it's important to remember that the words we choose to use are powerful. They can shape perceptions and increase or decrease stigma, especially when labels such as “violent” are used to describe a person with dementia. While the behaviour of a person with dementia may manifest itself as being violent, it's important to remember that their behaviour is often a response to what's happening around them.

Dementia is an overall term for a set of symptoms that's caused by disorders affecting the brain. Many of us know about diseases such as Alzheimer’s disease. While any abilities lost with dementia will not come back, the pursuit of meaningful relationships and activities is indeed possible.

Today I will provide this committee with brief information on the following: how disease pathology may influence aggression, structural or environmental factors that can reduce the risk of aggressive incidents, the benefits of a person- and relationship-centred rather than a task-centred approach, and the role of medications.

All behaviour has meaning and happens for a reason, although the reason may not be obvious at first. When a person with dementia behaves aggressively, it's especially important to understand what may have triggered this aggression, by considering the following.

First, the disease pathology itself may lead to aggression. People with dementia experience changes in the brain that can affect their abilities, such as language; judgment; sensory perception; and recognition of people, things and places.

Changes that happen in the brain because of the dementia may affect the person’s judgment, emotions and self-control and can contribute to aggressive behaviour. For example, damage to the front part of the brain can affect an individual’s personality and their capacity for empathy, impulse control and judgment. These are problems often seen in fronto-temporal dementia and can result in physical aggression without any obvious provocation.

Since our brains help us interpret the world around us, dementia can impair our ability to accurately assess and respond to what's happening in our environment. For example, when a care provider, whom a person with dementia does not recognize and who seems to them to be a complete stranger, approaches them to assist them in disrobing for a bath, the person's instincts are often to resist and even to fight back. When we reflect on what we would do if approached by someone we don't recognize who proceeds to remove our clothing, this reaction makes sense. In fact, we frequently refer to these actions as "responsive behaviours". Therefore, ascribing a label of "violent" to a person with dementia may discourage us from looking closely at the reasons for their behaviour and seeking ways to reduce the likelihood that the person needs to react in this way.

Being mindful that one's perception is one's reality, we need to constantly try to see the world from the perspective of the person with dementia and resist the temptation to blame them for unacceptable and inappropriate behaviour, such as aggressive outbursts. This appreciation for the reality of people with dementia in no way minimizes the devastation for providers, individuals and families when aggressive incidents occur. In fact, the onus is squarely on those of us without dementia to understand the root causes of the person's actions in order to lower the risk of such incidents occurring and reoccurring.

The second issue are the structural issues that are systemic in nature that may result in aggressive incidents. If these are not addressed, we are at risk of tackling the issue of aggression in a piecemeal fashion, one client at a time . Examples of these issues include the design of the built environment. For example, long corridors that end in a dead end can leave a person with dementia, who may not have the problem-solving skills to navigate a new path by turning around, feeling cornered and trapped. Being approached by a well-meaning staff person to assist with navigation may trigger a fight-or-flight response in the person with dementia.

With regard to inappropriate and oftentimes unsafe client-staff ratios and unreasonable staff workload, as we've heard, health care providers are often rushed, unable to spend time getting to know the person with dementia and building the type of relationship that can lead to a sense of trust and safety. A person with dementia can easily become overwhelmed by demands made on them, and frequently needs more time to process what is being asked of them. When rushed and overwhelmed, a person with dementia may well respond aggressively out of frustration.

● (1605)

Heavy reliance on the use of agency staff can result in less continuity of staffing, thus negatively impacting the staff's ability to know each person with dementia well and develop relationships.

Lack of meaningful activities resulting in boredom and frustration. There's evidence that engagement in arts and leisure activities like music, visual arts and animal therapy is linked with a reduction in neuropsychiatric symptoms, including aggression.

The above, of course, is all predicated on truly knowing each person with dementia as a whole person. This leads us to the importance of a person- and relationship-centred approach to dementia care. The goal of this approach is to support people with dementia to experience joy and engagement and connection with others and a sense of security. The evidence is mounting that valuing the person with dementia and bringing relationships to the forefront of care, rather than relying on a task-centred approach, is beneficial for both staff and residents. This, however, requires a shift from care routines that are beneficial for staff to those that are supportive of the clients' routines and preferences, and this shift needs to be supported at the level of organizational structure so it's not piecemeal.

For example, a person with dementia who's not a morning person will likely resist staff efforts to get her up and dressed at 6 a.m. While this schedule might work for staff, given organizational demand that there be a set schedule for activities, struggling to get a person ready for the day when they are accustomed to sleeping in later will likely only result in a poor experience for both staff and client. Knowing that a Holocaust survivor is terrified of showers, for example, will help staff appreciate that a sponge bath instead of a shower will avoid triggering a catastrophic reaction. We need to free staff to creatively problem-solve with those who know the person best. That not only leads to more effective care routines, but it also reduces the likelihood of aggression.

Finally, let us turn to the role of medications. Although it's recommended to try non-pharmacological approaches first, in some cases there are times when the above will not work, and in these instances medications may be needed.

Treatment of agitation and aggression with medication should only begin with an appropriate medical diagnosis ruling out any physical condition such as infections and medication side effects or even environmental factors. When the agitation is serious and represents a risk to the person with dementia, other residents or staff, certain medications can be used with appropriate monitoring and informed consent of the person with dementia or their substitute decision-maker.

It's important to monitor the response to medications and determine if there's a reduction in the frequency and the intensity of agitation and aggressive behaviours as well as monitoring for serious adverse effects, which have a high incidence among older adults. If the resident's behaviour improves, implementing a structured, scheduled re-evaluation for tapering and discontinuation of medications is important.

What can be done to reduce the risk of aggressive incidents? We know that from the research it's most likely to result from using a combination of the following strategies.

Structural and environmental changes include adequate staffing; structural changes to the way care is delivered in client-staff ratios and staff workload; personalized care where meaningful relationships and activities can be offered, especially at high-risk times like evenings and weekends; clearing clutter and adjusting temperature and lighting; minimizing noise; providing accessible quiet areas; closely monitoring residents at risk for aggression; offering private rooms when possible; and using dementia-friendly signage throughout the home, clearly labelling each bedroom to avoid residents entering someone else's room.

Education about dementia is also key for residents, families, staff and management. We need to educate management and staff on dementia, responsive behaviours such as triggers and consequences, person- and relationship-centred care, and the importance of supporting this through organizational change to enable care to be delivered in this way. We need to educate resident and family councils, families and staff on how they can work together to reduce the risk of future incidents.

Special training programs such as P.I.E.C.E.S and GPA can help everyone learn and apply effective care strategies and techniques to prevent and manage aggressive behaviours.

Behavioural assessments include having procedures in place to conduct pre-admission behavioural evaluations to get a detailed personal history of the person with dementia, specifically asking about known risk factors.

We need to look at pain identification and management. We need to routinely assess for pain and discomfort, especially in individuals who are non-verbal, as this may very well contribute to aggression.

● (1610)

It's the same with medical problems. We need early detection and treatment; regular medical, dental, hearing and vision evaluations; and of course optimal medication management.

Finally, there are the physical needs. Food and drink need to be regularly available to avoid hunger and thirst. We need to monitor for things like constipation, incontinence, personal hygiene, and even whether the person is too hot or too cold. Finally, we need to adapt the environment if the person has sensory impairments, as this can easily lead them to misperceive what's happening around them.

In summary, violence or aggression between care providers and people with dementia in any setting is not inevitable. We have evidence-informed approaches at our disposal to significantly reduce the risk of these incidents occurring. We at the Alzheimer Society of Canada urge this committee to enlist the help of researchers and clinicians, experts in this field, to increase the safety of care providers and people living with dementia, and to thereby improve the quality of life and care in Canada.

Thank you very much for your consideration and your attention.

The Chair: Thank you very much.

Now we'll go to the British Columbia Nurses' Union, by video conference from Burnaby.

You have 10 minutes.

Ms. Adriane Gear (Executive Councillor, Occupational Health and Safety, British Columbia Nurses' Union): Thank you for giving us the opportunity to speak here today.

My name is Adriane Gear. I'm the executive councillor for health and safety for the B.C. Nurses' Union. I'm joined today by BCNU occupational health and safety director, Moninder Singh.

Both of us are honoured to have been given this time to address the growing epidemic of violence against nurses in the province of British Columbia and across the country. It's an issue of significance for us and the more than 47,000 nurses and allied health care workers we represent.

I sit here today not only as an elected representative but also as a registered nurse who has spent close to 25 years in the field and has the personal understanding of what nurses experience every day while we strive to provide safe patient care.

Over the last 20 years, BCNU has been sounding the alarm about violence against nurses and health care workers. Two years ago, we launched the very successful campaign, “Violence. Not Part of the Job”. This has consisted of public advertising, member outreach and lobbying efforts with the provincial government. Our work has resulted in a significant increase in awareness about violence in health care. Our main message is that violence is not part of any nurse's job.

Despite this, I feel it's important to share with you just a few of the many personal examples of violence members have shared with me. This past Christmas Day in Victoria, a patient in an adult psychiatric intensive care unit attacked a nurse from behind and placed him in a chokehold. The nurse blacked out and then the patient proceeded to slam the nurse's head repeatedly on the ground.

That same month in Kamloops, a nurse who was 26 weeks pregnant was punched in the stomach by a confused patient. Thankfully, the baby was medically cleared. In Prince George, a young nurse, a new grad, was assaulted by a male patient in a premeditated attack. He waited until she was alone in the nursing station, then crawled along the floor before attacking her from behind. Luckily, the nurse had self-defence training and was able to fight off her attacker.

This past April, another nurse was struck from behind with a wheelchair footrest after a patient followed her into the room. While the nurse pulled the call bell to alert someone, she was again struck and she could not protect herself. It took three workers to pin down the patient. Security refused to assist due to physical inability.

Stories like these along with grim statistics provide strong evidence that more needs to happen. A 2015 WorkSafeBC report found that on average, 26 nurses a month suffer a violent injury at work in the province, and the injuries due to violence have been steadily increasing year after year. This is despite a general downward trend of claims across other sectors.

Just this year, the Fraser Health Authority, B.C.'s largest health authority, released a violence data report that found that the number of violent incidents reported in health care workplaces increased by 52% between 2014 and 2018. While we understand that violence is most prevalent in emergency and psychiatric units, it is not limited to just these areas of health care. We hear concerning stories coming directly from our members who work in community and home health, geriatrics, palliative care and critical care. Violence impacts all nurses in all workplaces in all health care settings.

A 2017 BC Nurses' Union survey, conducted in partnership with the University of British Columbia, found that only 27% of our members said that they always feel safe at work, and a sobering 40% said they were thinking of leaving the profession entirely, because of workplace violence. This level of despair pushes us to keep asking why.

● (1615)

Why is it that according to a WorkSafeBC report, more than 40% of the injuries that nurses suffered were the result of violence in the workplace, even more than security and law enforcement?

The BCNU is determined to find solutions and get to the bottom of this crisis that is impacting so many nurses in this province and around the country.

Data collected from a recent BCNU violence survey found that nurses felt safer when they had access to fixed and personal alarms that worked. Our members told us that the presence of appropriately trained security personnel—people who are there specifically to respond to an incident—made them feel safer.

Nurses told us that they wanted to be included in prevention planning, and we agree this action will both improve confidence and empower nurses. The survey also asked nurses to provide some suggestions of their own. Not surprisingly, many offered valuable insight. Respondents said the addition of well-trained security 24-7, better staffing, the enforcement of existing zero tolerance violence policies and the reduction of overcrowding in our hospitals would be welcomed.

We fully agree that all these recommendations if implemented would contribute to establishing a culture of workplace safety. We are also cognizant of the psychological impact of violence on our members. BCNU is the first union to negotiate the mandatory implementation of the CSA standard for psychological health and safety in the workplace. While we have been frustrated with the lack of progress in the implementation of the standard, we remain hopeful that once it's implemented the rates of psychological injury will be reduced.

Over the last year, we have been very busy applying pressure on the provincial government to stand up and deliver on promises to keep nurses safe. Last October, we delivered 25,000 signed postcards from concerned citizens to the Ministry of Health, demanding that violence in health care be eliminated. In addition to applying provincial pressure, we recognize the importance of engaging on a federal level to ensure nurses' needs are met.

We welcomed federal NDP MP Don Davies’s introduction of a bill to amend Canada’s Criminal Code to make people convicted of assaulting health care workers eligible for more serious sentences. A 2017 Mustel poll commissioned on behalf of the BCNU found that 84% of British Columbians support tougher sentences for criminal assaults against health care workers.

However, we want to make it clear that this change to the Criminal Code would only be applicable to people found criminally responsible for assault. The intent is not to criminalize behaviour that is due to medical circumstances or focus on patients with mental health needs. Our goal is to hold culpable assailants accountable, not target vulnerable patients.

We support the Canadian Federation of Nurses Unions' recommendations that national minimum-security training standards for health care environments need to be legislated, and protocols for responding to and investigating workplace violence incidents need to be established. The BCNU also proposes adding a related recommendation for national guidelines for communicating risk of violence in health care settings. The BCNU supports the CFNU's recommendation that federal funding needs to be targeted towards CIHI's collecting and reporting on health care facility-level workplace violence-related data. We feel that the routine collection of data at the national level will help to inform and evaluate progress on this important issue. We also believe this will help address some of the difficulties around the under-reporting of violence in health care.

Finally, while the BCNU supports the spirit of the CFNU's recommendation for a study into health human resources planning, we call for stronger language and immediate action. We know that Canada is experiencing a nursing shortage, and that the shortage is likely to get worse as the baby boomers retire. The BCNU is calling for immediate targeted funding for additional nursing seats in each province, and funding to hire the resulting additional graduates into new positions.

We believe it's important to work collaboratively with all levels of government, health care institutions and unions to effectively address this problem in all areas of our health care system.

● (1620)

I'd like to end by saying that all too often we hear statements like “Violence is part of the job” and “Is it really a crime?” It is this lack of understanding that motivates all of us at BCNU to work towards changing this culture. From the nurse manager in an emergency room to the federal politician in Parliament, we believe the safety of nurses and health care workers is everyone's responsibility.

Thank you.

The Chair: Okay. Thank you very much.

Now we'll go to the Public Services Health and Safety Association.

Ms. Henrietta Van hulle (Vice-President, Client Outreach, Public Services Health and Safety Association): Thank you for the opportunity to speak to you today.

My name is Henrietta Van hulle, and I am a nurse with 17 years of front-line care experience before shifting to occupational health nursing. I am the vice-president of Ontario's Public Services Health and Safety Association, PSHSA.

PSHSA is a non-profit organization, funded by the Ontario Ministry of Labour, with a mandate to reduce and prevent work-related injuries, illnesses and fatalities.

As a product and technology organization, we focus on advancing intelligent safety. We leverage technology to drive change in health and safety outcomes, which enables us to stay ahead of the curve.

PSHSA has been actively involved in furthering violence prevention efforts within Ontario's health care community, and I'd like to spend a few minutes sharing what we've been up to.

Our journey began when PSHSA, along with its stakeholders, noticed, similar to what we've heard today, an increase in the severity and frequency of violent events towards health care workers. Nurses and personal support workers, PSWs, here in Ontario were being stabbed, punched and sexually assaulted, and we knew it had to stop.

Along with the Ontario Nurses' Association, we met with the Ministry of Labour to discuss how we could lead the province with the development of some new resources. This led to our violence, aggression and responsive behaviour, VARB, project. We included the term “responsive behaviour” as there are many events, as you've heard from others, where there is no intent to cause harm to the health care worker. However, these situations still require strategies to mitigate the harm that could occur.

In our VARB project, we used an evidence-informed approach that started with a literature review, a jurisdictional scan and input from focus groups. We engaged multiple stakeholders from various levels and subsectors across the health care system in Ontario to identify priority areas that had a focus on prevention of injury.

We further refined those to make sure that the topics that we chose would produce usable tool kits and would support consistent, scalable and consensus-based approaches for violence prevention. This led us to the development of five tool kits.

The first began at the foundation for prevention and was designed for completing workplace violence risk assessments at the organizational and the departmental levels.

The second tool kit focuses on the patient as the source of the most common type of violence that occurs in health care, and it was designed for conducting individual client risk assessments that assess observed behaviours and are not focused on diagnoses.

We then moved to making sure that everyone would be aware of the risks that could be assessed, and we developed a risk communication or flagging tool kit that we've heard others speak about.

This was followed by a security tool kit to assess what type of security and/or training programs are needed in the health care setting.

The fifth tool kit is the personal safety response system, a guide to ensure that workers at risk of or involved in a violent event have the means to call for help.

The design and development of the tool kits was led by one of our health and safety specialists with support from a working group that included both management and front-line staff from across health care. We also engaged our product development team in the knowledge translation tools that were developed to support the tool kits.

We further refined the tool kits by combining technology and subject matter expertise. We created a website and automated interactive risk assessment that supports employer self-sufficiency and subsequently provides a cost-effective solution for organizations to improve their workplace violence prevention programs.

The tool kits were so well regarded that, in 2017, a joint Ministry of Labour and Ministry of Health and Long-Term Care leadership table on workplace violence in Ontario recommended the use of PSHSA's tools in all Ontario hospitals.

Two years following the launch of our VARB tools, there have been over 20,000 visitors to our website, and a recent evaluation of the tool kits found that 75% of Ontario's public hospitals are aware of the tools and that 67% are actively using at least one of the tool kits. The researchers have told us that this degree of awareness and uptake is unprecedented for this type of complex intervention.

● (1625)

Since then, we've used the same approach to develop four additional tool kits at the express request of the joint leadership table, many of which, we've heard today, are needed. These tool kits focus on incident reporting and investigation, patient transit and transfer, code white and work refusals. They will be released this summer. We believe the path forward for Canada is to scale some of these regional successes to effect sustainable change. In fact, we have already shared our resources with members of the National Alliance for Safety and Health in Health Care, and four provinces outside of Ontario are actively using at least one of the tool kits. We shared our approach at the recent International Conference on Violence in the Health Sector, and have been approached by other countries for use of the tools.

While regional adaptations may be needed, the general solutions required to address workplace violence are fairly consistent, as we've heard, and we're happy to share our work. We also support many of the previous speakers' recommendations on things such as the need for staffing ratios, human resource strategies that will make sure we have sufficient staffing available, infrastructure investments, and the need for a national standard for workplace violence. In fact, PSHSA and the CSA Group are currently working together on a research project to identify whether there is a need for a national standard on workplace violence and harassment. A report will be published this summer by the CSA Group. Based on our experience thus far, we have five additional recommendations to put forward.

Number one is to spark a paradigm shift.

This first recommendation speaks to the way violence is viewed in health care workplaces. We believe that a fundamental shift in thinking needs to take place in two key areas. First, health care employers consider violence an occupational health and safety issue, but it needs to be considered a care issue. There is absolutely no hope for quality care without considering worker safety. Having safe health care workers means having better care. Second, there is an inequality in the way many organizations treat physical safety versus psychological safety. The prevention of psychological harm has been less of a focus, and there are fewer supports available. It needs to be reinforced that workers' psychological safety is just as important as their physical safety.

Number two is to conduct actionable research.

We feel strongly that there is sufficient evidence—as Dr. Keith mentioned, over 1,000 studies—around the risks, occurrence, severity, effects and contributing factors to workplace violence, but now it is time to evaluate leading practices and the types of interventions that are being used to make sure they're reducing the risk of violence or to tell us more about what is and what isn't working.

Number three is to supplement health care curricula.

Beyond the necessary clinical knowledge, health care students require base-level safety training to ensure they're work-ready in a way that allows them to deal with escalating behaviours. This would include awareness, effective communication skills, recognition of escalating behaviours, de-escalation techniques and situational awareness. This training is not intended to replace existing leading practices, such as those that have been mentioned: the GPA program for older adults, which is in use in all but two provinces and territories across Canada; or the organization-specific training that may be required for dealing with specific populations.

Recommendation four is to enhance accountability.

Unless organizations are held accountable, we can't blindly hope for change. In our province, there is no mention of workplace health and safety within health care organizations' service accountability agreements. As a result, we recommend that all funders explicitly require health care workplaces to integrate worker safety into care practices.

The last one is to amplify public awareness.

While those of us working in the health care sector and those close to it are aware that violence is a pressing issue, there is little awareness on a mass scale about the risks that health care workers face on a daily basis. A public awareness campaign that communicates the government's position would call attention to the issue. Further, we encourage support for Bill C-434, under which assault of a health care worker will be considered an aggravating circumstance for the purposes of sentencing.

● (1630)

This bill will send a strong message that those who provide critical services such as health care must be treated with respect and have their safety and security protected.

Thank you, again, for the opportunity to speak to you today. We are grateful and heartened to see that the federal government is taking this issue seriously. We look forward to working together to effect healthier and safer workplaces.

The Chair: Thank you very much to all of you for your testimony.

We now go to our seven-minute round of questions.

We're going to start with Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you all for being here and for raising all the issues.

The first question goes to Dr. James Brophy or Dr. Margaret Keith.

You said you published two books. You mentioned an intoxicated person attacking...prevention can be accomplished.

We heard from Public Services Health and Safety. They have a tool kit. Do you think that tool kit can be factored into that long-term or hospital setting?

● (1635)

Mr. James Brophy: Of course, I think everyone appreciates that education and more training have some useful and important roles to play.

Essentially, we have a serious crisis, in our view, within the health care system that has deep structural problems and can't really be addressed simply at the level of further individualized training. There are many people engaged in this issue. There are deep structural problems...levels of staffing and procedures in place.

One of the things that we learned in our two studies was that the regulatory system in many ways has collapsed whether it's at the level of the Ministry of Labour, inspections, and enforcement of the laws, or the compensation system. Many of the health care workers won't even file compensation claims because they feel further traumatized in the whole process. We have a really deep structural set of issues that I don't think are at the level that can really be effectively addressed by simply going forward, more training, and so on and so forth. Of course, it's important, but it's not going to get at this issue, which is escalating.

Ms. Sonia Sidhu: Thank you.

I want to ask a question to the Alzheimer Society and the BC Nurses' Union.

Structural and environmental changes and education is the key. Do you think when we are talking about the health care providers' safety, we need to educate them? How important is it to educate patients or patients' families?

Ms. Mary Schulz: We certainly approach this from a multi-pronged approach, as our previous speaker has just identified. There is no one answer that's going to be a silver bullet here. Certainly, it's going to take everyone working together.

On your point about education, we know clearly from people with dementia and their families that they will often get to a long-term care home quite late in their disease process without ever really having understood and been told clearly what their disease is and what their trajectory is likely to be. We really need to have every opportunity to have conversations as collaborative team members among staff, residents or clients, and families, including the residents and family councils that exist in many organizations. It's when we get everybody together and start to very transparently look at these problems, without blaming, that we can actually get somewhere in terms of creative strategies.

I think many of us today have said very common things. There's not one approach that's going to work. Education is not going to be the whole answer. Structural changes, I would put, are not the whole answer either, because tomorrow we still have people working in these fields who can do a better job of approaching, in our instance, people with dementia. So, it is going to take a multi-pronged approach. To your point, I would say it takes everyone's heads coming together.

Ms. Sonia Sidhu: Thank you.

I want to hear from the British Columbia Nurses' Union.

Ms. Adriane Gear: Really, all we can do is echo what the previous speakers have said. Absolutely, education and training are paramount—not just a one-time shop, though. For appropriate violence prevention strategies and training, I think there need to be ongoing simulations and practice, but that is only one piece of the puzzle.

We absolutely need appropriate facilities for our elderly people. We also need specialized units for patients who are suffering with mental health issues. As well, there are systemic challenges such as overcrowding and access to appropriate treatment.

A lot of these issues also have to be addressed, but yes, ongoing education and training certainly are part of this.

I would just look to my colleague Moninder to see what he'd like to add.

● (1640)

Mr. Moninder Singh (Director, Occupational Health and Safety, British Columbia Nurses' Union): We feel that the education portion is effective in a setting where basic needs are met, and those basic needs would start with staffing levels, along with decision-making on behalf of the employer's side as well.

There's a strong feeling that a culture of safety doesn't exist within the health care system. Having worked on the employer's side as well for a number of years, in a senior position, I see that all the time. There's a shortage of nursing, but there's also this decision-making. Violence occurs on the job, but then who's making the decision to actually put people—workers, nurses, health care workers—in situations where that violence can occur and why?

A lot of it comes back to the fact that we're short of people. We don't have enough. We can't call for overtime; we don't have the funding for that. There's a cycle involved in this that goes beyond just the environmental concerns; you can build the infrastructure.

Also, I would definitely like to echo the last two statements that were made around how education is key. We do feel that it is, but education can only really work when those basic needs are met.

The Chair: Your time is up.

Now we're going to Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair, and thank you to the witnesses.

Certainly, this is an important issue. My daughter is a nurse, and when she was a student nurse she was attacked by a patient in the psych ward. My sister-in-law is also a nurse, and she was attacked by a resident in a long-term care facility and has permanent neck damage as a result. We really need to find solutions.

I'm going to start with Mr. Brophy and Ms. Keith. You talked about one of the solutions being to flag aggressive patients. When you identify somebody who is aggressive, what are the recommendations to deal with them? Are you going to restrain them? Are you going to medicate them? Are you going to have more people on or call the security guard? What are the measures you recommend?

Ms. Margaret Keith: I think there are a number of issues around all of that too.

We did find when we were doing our research that there was very inconsistent flagging. Not every facility uses flagging. In some cases, it's felt that it's stigmatizing, so they want to find ways of communicating to the staff that a person may have aggressive tendencies without stigmatizing the person. We heard a lot of different ideas on how all of that might be handled.

The big problem is that you might have someone who was acting very aggressively on a previous shift. If that information is not passed along to the new shift coming in, they can be in danger. There are a number of health care worker occupational groups that are not in on the nurses' huddles at the beginning of a shift, where you talk about what's going on with the various patients and residents. For people working as PSWs or dietary staff, there needs to be some mechanism for them to know that they may be walking into a situation that could be dangerous. If you have someone who is being aggressive, you need to look at all those ways in which you might be able to de-escalate this.

We did hear about people who were chronically aggressive, where people just knew that they would need to have three or four people go in. A football player with an acquired brain injury would require four staff people to hold him down while they changed his incontinence brief and that sort of thing. It's important to know these things, and sometimes you do need additional staff.

Besides all of these strategies we've heard about today that you can use for people who have dementia, there are other people who are aggressive for other reasons. They may be in terrible pain. They may be fearful. We need to look at what's going on there.

For the flagging, I think it's unfortunate that it may sometimes stigmatize, but I think we absolutely have to be doing it for the safety of the health care worker.

Ms. Marilyn Gladu: I fully agree.

When it comes to increasing the criminality of attacking a health care worker, I think Bill C-434 is a good one. I don't know if you remember the incident where there was a fellow on a bus who killed another fellow and got off because of his mental health condition. While increasing criminality might be a disincentive for people who are of sound mind, I'm worried that for those with mental health disorders, that's probably not going to be the thing. What are the important things that we should do?

I'll start with Mary Schulz from the Alzheimer Society.

Ms. Mary Schulz: I can't speak to mental health issues generally. I can only speak to dementia. Certainly, when we're talking about someone with dementia, we are typically talking about somebody who is fairly advanced in the disease. This is someone whose brain has become so damaged that their ability not only understand their behaviours but also to appreciate the consequences has become very damaged. Being held to account for that behaviour would by and large be inappropriate and unhelpful.

As we said earlier, and as we just heard from Dr. Keith and others, it's important that we do take the time and have the resources to be able to understand the antecedents for the behaviour. P.I.E.C.E.S. is the acronym for a model that's very widely used across Canada to really take apart why that person on the previous shift might have been violent or aggressive. In Ontario, we have GEM nurses in emergency departments and other areas who can be resources to staff as they step back and try to understand what might have triggered this behaviour. We need to understand that emergency departments, for example, are among the most toxic places for most of us, but particularly for people with dementia. The noise, the lights, the alarms, the sirens, the sounds and the people throwing up—all of that happening is an absolute recipe for frustration and aggression for someone with dementia.

We do need to think about physical design and education, but we also need to think about resources to staff in the moment to try and step back and figure out what might be going on and what they know about the person.

● (1645)

Ms. Marilyn Gladu: That's very good.

What about the B.C. Nurses' Union? Do you have any specific recommendations for dealing with patients who have mental health issues?

Ms. Adriane Gear: I think our first recommendation would be to invest in our mental health care system. We need to make sure there are proactive strategies to support those living with mental illness. We certainly want to see a reduction of stigma, and that there's access to care.

Unfortunately, what happens in a lot of cases is that patients have decompensated to the point that they are in a real crisis. It's in those situations that we are seeing an escalation of violence. If we can provide appropriate care in a timely way, I think that would go a long way toward addressing some of the violence we see within that population.

It's access to care.

Ms. Marilyn Gladu: Very good.

Now I have a question for Henrietta. I'm surprised. I come from a chemical engineering background. We have the Green Book in Ontario, which should make any employer who has workplace incidents of violence and harassment going on follow up. Does that not apply to hospitals? Why are employers like hospitals and long-term care facilities not doing their due diligence in some cases?

Ms. Henrietta Van hulle: I think the focus is on care rather than on prevention of occupational health and safety injuries. I think most of them understand the requirements of the book, but without the tools and resources, they struggle to implement them. I think that's the bigger issue. That's one of the reasons we've developed the tool kits. All of them kind of point to a piece of the legislation in Ontario, which is actually doing that risk assessment first, doing that assessment of the patient where the biggest risk is. Ms. Sidhu had asked about things like intoxication and withdrawal. Those are the types of things that are assessed at that level. Then there is the flagging, which really is risk communication. Whenever there is a risk from any type of hazard, it needs to be communicated. That's part of the flagging process. It's not dissimilar to what you would do if a patient had an infectious disease in a health care setting. You would need to communicate that to everyone who came into contact with that person. It's the same thing when there is a risk of violence.

The Chair: Thanks very much.

Now we go to Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Thank you, Chair; and thank you to all the witnesses for a really interesting presentation.

I want to start with my friends from the B.C. Nurses' Union.

Ms. Gear, thank you for your presentation. I have a question for both you and Mr. Singh. I really appreciate what you have told us and the work that you're doing.

For example, I'm very impressed with the brochure, “Have You Experienced a Violent Incident at Work?”, which says in very clear terms, “Here's what to do”. I think it is empowering to the nurses who you represent.

Marilyn Gladu talked about her family member. I have a sister, Joyce Rankin, who's a nurse in Toronto, and she has told me about the increasing problem that you've all put your finger on. I don't think Canadians really understand.

Thanks for your anecdotes about Victoria, Kamloops and Prince George. I was particularly disturbed when you said that 40% of members in your survey might be considering leaving. My goodness, we have a shortage already. To think 40% might leave just because of violence is extremely sobering.

Before asking my question, I want to thank you as well for supporting my colleague Don Davies' private member's bill on the sentencing issue, although you were quick to say that criminalization is not the way to go but only part of the solution.

Here's my question to start.

Regarding your brochure that I referenced, about experiencing violence, I have two things I want to ask. First, you talk about calling the nurses' violence support line and you give a 1-800 number for that. Do you have any data on how many people are calling and what the implications of that have been? Has it been a good idea? Should other nurses' unions across the country or employers do a similar thing?

Then, as the final point on what to do, you say, “After a traumatic incident, you may benefit from a critical incident stress debriefing”. I want to hear what that critical incident stress debriefing entails.

● (1650)

Ms. Adriane Gear: The violence support hotline was really something that came about because our members told us that it's very difficult to report. Although there are processes in place, it's confusing. There is so much documentation and there are so many requirements to report unsafe patient events, it gets confused with reporting events that impact worker safety.

We were also told by our members that they didn't feel supported when they reported violence, that some of the questions they were asked really were almost blaming: “Well, what did you do to provoke the violence?”

For those reasons, and to gather additional data, we thought it was important to provide a support line. What happens now is that our members do have the option of calling BCNU directly.

What we do is help navigate, because this doesn't replace the requirement to still report to the employer and participate in workplace investigations, but it does allow us, at a time when somebody has been physically and/or emotionally traumatized, to provide that support and help navigate the process, which is quite cumbersome. We can also initiate other elements of recovery supports from our union.

It has been successful. Certainly we don't find that nurses are calling in the moment, but usually it's after the fact and just to get some additional support. A lot of times, nurses want to be heard. Even if they don't want action taken, they want what has happened to them to be validated.

It has been successful. I don't have data with me, but if you were interested, I could certainly follow up and get you some of our findings.

Mr. Murray Rankin: I'd appreciate that. I think that would be useful.

I'm asking this next question of all the witnesses who wish to answer, and perhaps Ms. Schultz in particular.

We heard a lot about psychological versus physical violence. Linda Silas, who is the president of the Canadian Federation of Nurses Unions, says that the law should be simple: “If you hit a nurse, you go to jail!” That sounds as though it's a pretty simple message, but when you think about people with psychological harm, it really doesn't work, because of course, criminalization, having to have the mental element, might not apply if you are suffering from dementia or Alzheimer's, or the like.

I'd like to know, then, if criminalization isn't the answer, what you think should be the answer for people with psychological damage. What should we do? I've heard a lot of things about how we should make the workplace safer, about the structural problems with understaffing, and not leaving people alone on the shift.

In particular, Dr. Margaret Keith and Dr. Brophy's study talked about 56 participants, just seven of whom were men. Women are obviously disproportionately impacted. Are racialized Canadians also disproportionately impacted?

I'd like you to talk about that, and if you have an opportunity to talk about the psychological aspects, people with psychological harm and how we can address those issues, I'd be grateful as well.

Mr. James Brophy: You have asked a lot of questions, and I'm sure all the people at the table want to talk to you about those issues, because they are fundamental to what's going on in health care.

I think we need to ask why the prevalence of violence is so widespread in the health care setting, where it far exceeds the level of violence that even police and corrections officers face. Why, in almost every statistic across the country, do we find that health care staff are suffering rates of violence far in excess of any other occupation?

You mentioned the issue of women, and I think it's fundamental here. This is an occupation in which women predominate, and violence against women in our society is a major issue. The way violence is treated in the health care setting is so reminiscent of how domestic violence is treated.

As our friends from British Columbia have said, health care workers are blamed. Most post-incident briefings, or debriefings, start off with, “How did you approach this person?” The onus is already on the health care person, as if their behaviour is the source of the problem.

This issue of why the public doesn't know about this has been brought up a number of times. I agree; the public does not know. One of the factors is the fear of reprisal that health care staff across the country fear and face.

In Ontario, a nurse spoke out at a conference on violence, didn't name her workplace and simply said that violence was a major issue. When she returned, she was fired. The union engaged for almost two years in an arbitration case, spending hundreds of thousands of dollars that finally brought this person back to work.

When we conducted our study, in every single community we went to, the session started with people saying, “Protect us. We don't want to be identified. We know about this incident of someone being fired. We are afraid of speaking out.” Again, this is very much paralleling the attributes, if you will, of violence against women in our society, and how it is treated.

● (1655)

The Chair: I'm sorry. We have to move along now. We're over time on that question.

We're going to move now to Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair. Thank you all.

I hope I can get through all of the questions I have, in the time I have.

I'm a physician. I worked in emergency for 20 years and, of course, I saw pretty much every department in the hospital during my training.

One of the problems I saw all through my training is that you would have a patient who is confused—whether this is dementia, or some other process—and at risk of wandering. They would sometimes fall. I've seen broken hips in patients who fell out of their beds because they were confused. I've stitched up a few heads.

There was always a Catch-22. Physical restraints are considered unsuitable and inhumane. You would have sedatives, but there is more of a push that you have consent from families. Some families don't consent to this, and we don't have staff available for 24-7 care.

I'm going to throw this out to the B.C. Nurses' Union first. How do we balance these competing priorities, when we're left with no option that is acceptable?

Ms. Adriane Gear: That's a great question. I wish I had the answer. That is the issue. We want to provide safe, ethical care to our patients. We want to make sure there are enough staff to safely provide dignified care.

The reality is that care is being provided in environments that lack resources. They lack human resources. I think that's why we're looking to you. We need to have some kind of support. Provide us the staff, training and appropriate environment, so nurses and health care workers can do what we do best, and provide care to those people.

We recognize that in those situations where you have a demented elderly person who's confused, they are scared. Their behaviours are not directed at us personally, but the reality is that nurses and other health care workers are becoming injured. We don't have enough of us already. We're looking to you, as the decision-makers, to create change, so we can have safe health care places for our patients.

● (1700)

Mr. Doug Eyolfson: Okay, thank you.

I'll ask this of you because this is, again, an issue with the nurses' union, and I will ask Ms. Van hulle as well for her take on this.

I am from Manitoba. There has been a recent change to the Mental Health Act in Manitoba. When a patient was brought in with a suspected psychiatric complaint, the police would be called. If the patient was to be moved to another facility, the police would be the ones to transfer them if there was a safety issue. If they were picked up in the community, the police would take them in, and they would have to stay with the patient for safety until the patient had been seen and it had been determined that they were admitted to a suitable facility.

This change to the act says that the police no longer have to wait, because the province says that there are more people in the hospital with the training to deal with them; however, there is not more staff.

Can you see any safety considerations or implications with this change?

Ms. Adriane Gear: I think that is disastrous. The reality is that mental health patients come into our emergency rooms, and they sit for hours, sometimes days. They sit on stretchers in bright lights, and they're in very exposed areas so people can observe them. We have floor cleaners going by, lots of noise and lots of things to trigger them.

Leaving them unattended is not the answer, although I absolutely appreciate the challenge, of course, that law enforcement needs to move on and do what they do best.

Again, I go back to our needing appropriate, timely access for people who are suffering with mental health issues, so that's the problem.

Mr. Doug Eyolfson: I would tend to agree, and Manitoba's nurses' unions agree as well.

Ms. Schulz from the Alzheimer Society, this is something that's been a problem. It's been going on for years, certainly in my own emergency medicine practice in Manitoba. This may be happening in other provinces.

Patients with dementia would present to the emergency department from the community. Very often they live alone, and a concerned neighbour has found them wandering in their pyjamas in January. They obviously can't go home because there is just no stable environment for them.

What has been the practice, at least in Winnipeg's hospitals, is that the people who are in charge of admitting patients—deciding that a patient goes to a ward—have policies there now that they will not admit patients to hospital if there is no acute medical problem. If the only problem is dementia, they are kept in the emergency department until an appropriate centre is found for them.

This has, on more than one occasion that I can recall, taken over a month. You didn't mishear that. We're talking about a patient with dementia spending a month in an emergency department.

Is this ethically defensible?

Ms. Mary Schulz: I'm afraid part of that question is out of my scope, but what I certainly can respond to, sir, is that it is not uncommon to have this kind of scenario played out right across this country, unfortunately.

When you say that the person has come with basically no medical problem other than dementia, I would respectfully remind you that dementia is a medical condition, and that a person arriving—

Mr. Doug Eyolfson: Yes, and I would agree with you on that, but it appears that our people in charge of internal medicine disagree with us on that, but I agree with you, completely.

Ms. Mary Schulz: Absolutely, I am sure, and there is quite a lot of awareness that needs to be raised among health care providers that the reason that person with dementia arrived in emergency today instead of yesterday or three weeks ago may well be that something has triggered it. There is some reason why the person has arrived in emergency today. Why did they wander; what triggered this; do they have a urinary tract infection; what's going on? They do deserve a thorough medical workup to ensure that there is no medical condition other than the dementia going on.

If, in fact, it is a chronic acerbation of the dementia itself, that's where we get to what I think our colleagues in B.C. have been saying, that we're looking for structural change where that person has a step-down unit that's appropriate to move to in order to free up that emergency bed.

I would put to this group—and I am putting words into folks' mouths, perhaps—that I think we are talking about a culture change. We're talking about not just looking out for the person who has a mental health condition or dementia; we're looking to design environments, assuming that no one is at their best in emergency, no one is at their best when they're in pain, no one is at their best when they are in acute care, and no one is at their best when they move into a long-term care home.

We need to have that basic bar where everyone will benefit from a dementia and mental health-friendly environment where the floor cleaners are not going by at two in the morning, where the lights are dimmed to the extent possible and where there is perhaps classical music playing. These things have been shown to decrease agitation, and if we could start to make that the norm rather than triggering who is on our wait-list who is really at risk for hitting out, I think we might all benefit.

● (1705)

The Chair: Thank you very much.

Now I have to wind up the questions with that round. We have some committee business we need to do because of the winding up of Parliament. We have to get it done today. I want to thank our witnesses very much for your information and for helping us to understand how serious this issue is. We appreciate you taking your time to do this. On behalf of the entire committee, thank you all for your help.

We will suspend for a few minutes, and then we'll come back in camera.

[*Proceedings continue in camera*]