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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1605)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome to meeting 150 of the Standing Committee on Health. I'm sorry that we're late. There's a little bit of chaos these days that we have to deal with. We'll proceed as quickly as we can.

We're going to open our testimony on violence faced by health care workers. Today, our guest from the Canadian Association for Long Term Care is Jennifer Lyle, liaison for the National Alliance for Safety and Health in Healthcare. Joining us from the Canadian Union of Public Employees is Jenna Brookfield, health and safety representative. From the Hospital Employees' Union, by teleconference from Burnaby, British Columbia, we have Georgina Hackett, director of occupational health and safety; and Alex Imperial, representative. From Liberty Defense is William Riker Jr., chief executive officer.

Welcome to you all. Each one of you has a 10 minute opening statement, and then we'll go to our question period.

We'll start with the Canadian Association for Long Term Care. You have 10 minutes.

Ms. Jennifer Lyle (Liaison, National Alliance for Safety and Health in Healthcare, Canadian Association for Long Term Care): Thank you.

My name is Jennifer Lyle. I am the CEO of SafeCare BC and one of the founding members of NASHH, the National Alliance for Safety and Health in Healthcare. I am here today on behalf of CALTC, the Canadian Association for Long Term Care, as the NASHH-CALTC liaison.

CALTC is a national organization composed of provincial associations and long-term care providers that publicly deliver health care services for seniors across Canada. It also represents care providers who deliver home support services and care for younger adults with disabilities.

The National Alliance for Safety and Health in Healthcare, NASHH, is a national-level collaboration of workplace health and safety associations that works with health care organizations and workers across Canada to promote safer, healthier workplaces.

Mr. Chair, honourable members, our continuing care sector is in a state of crisis. Our care providers are understaffed, under-resourced and under incredible pressure to provide quality care to an increasingly complex population. This set of factors creates a toxic mix that not only leads to burnout but also to workplace injuries.

Consider the numbers. Nationally, time lost claims due to violence in health and social services have increased by over 65% in the past 10 years. In B.C. alone, health and social services account for over 60% of all workplace violence claims among major industry groups, according to WorkSafeBC, and yet this sector amounts to only 11% of the total provincial workforce of this group.

Overall, violence is one of the leading causes of workplace injuries in B.C.'s continuing care sector, and B.C. is not unique. Across Canada we all face the same challenge: how to address the root causes of workplace violence in health care.

In order to address the root cause of an issue, you first need to identify and understand it, and that leads me back to my earlier remarks about being understaffed, under-resourced and under pressure.

To understand the pressure care providers are under, you need to understand how those relying on the continuing care sector have changed over the past decade and where we're headed. Today 62% of long-term care and 28% of home care clients have some form of dementia, a number that's expected to increase. By 2031, over 937,000 Canadians will have dementia. That's an increase of 66% from the present day.

In addition to the trends we see around dementia, we're also seeing an overall increase in complexity of the needs of those being cared for in a community setting as we continue to move away from an institutional model of care. This includes people with psychiatric disorders and addictions who may also now be facing dementia as they age. These things are all risk factors for violence.

Violence is not a foregone conclusion in any of these instances, but too often our system puts care providers at risk because of how care is being delivered. That brings me to my next point—being understaffed.

In a recent survey conducted by SafeCare BC of the continuing care sector, 95% of respondents indicated that their organization was short-staffed. You might wonder what staffing shortages have to do with violence; in that survey, we asked. We asked how staffing shortages impact care provider safety, and what they told us is that staffing shortages lead to rushing, to fatigue, to feeling like you don't have time to ask for help. All of these things put care providers at risk.

Not only that, but when you're working with vulnerable populations—for example, seniors with dementia—it's vital that you have the time to understand their needs and their triggers, yet it's this time that's in such short supply for our care providers because of chronic staffing shortages.

Not only that, but just as staffing shortages lead to workplace injuries, workplace injuries lead to staffing shortages. Take B.C. as an example. In 2018 the equivalent of nearly 650 full-time positions were lost because of workplace injury. Imagine an organization—or several organizations, for that matter—losing that number of full-time employees. Imagine the impact. That's the cost of workplace injuries.

Beyond the numbers, there is the human toll. There is the care aid who is sexually assaulted by a home care client with dementia. There is the nurse who is punched in the jaw by a senior suffering from delirium. There is the personal support worker who doesn't know how she could possibly face going back to work. Finally, there is the senior whose care is impacted because the person they rely on, the person they have developed a relationship with, is no longer available to help because of workplace injury.

What can be done? One option is a renewed national health human resource strategy—one that incorporates a seniors care lens and a workplace safety lens, one that reflects the changing demographics of our society and the shift towards community-based care, and one that places both the physical and the psychological well-being of our care providers at its centre, because ultimately we're talking about people, people who are trying to do the very best they can with what they have.

That brings me to my last point: being under-resourced. This is a big topic, so for brevity's sake I'll focus on three key areas: infrastructure, education and data.

From an infrastructure perspective, research has proven the power of design, specifically dementia-friendly design. Dementia-friendly environments support the person with dementia and minimize the risk of responsive behaviours. Put simply, dementia-friendly environments are not only associated with better care, but they're also safer for the care providers.

However, we face significant challenges across the country. CALTC estimates that 40% of care homes need significant renovation. In B.C., the average age of a care home is 30 years. A lot has changed in 30 years. Our understanding of dementia and the power of smart design has increased significantly, and at the same time, seniors entering care homes have changed. Gone are the days when a senior would drive herself to the care home and unpack her own suitcase. The care homes in which these seniors live are no longer designed for their needs, and that absence of design affects both the quality of their lives and the safety of the care providers who support them.

The federal government has an opportunity to make an impact in this area. One opportunity is to build on the $6 billion in community health investments made in the Investing in Canada plan to include investment in care home infrastructure, because, make no mistake, these are not care facilities or hospitals: These are people's homes. Such investments could be used to incorporate the last three decades' worth of research and knowledge into retrofits and new builds that better support safe care.

Our care providers are also under-resourced when it comes to education. Presently there's no national standard on workplace safety core competencies for health care workers, and there's also significant variation between health care occupations as to what core competencies are required.

Part of our work at SafeCare BC has been focused on making inroads with this group for that very reason. Working in continuing care is a high-risk activity, and therefore all health care providers should be required to exhibit baseline workplace safety competencies prior to entering the field, yet we see that this is not the case.

Part of this stems from a lack of awareness, and therein lies opportunity. There is opportunity for a public-facing campaign to raise awareness of the issues of violence in health care and the tools and strategies available to mitigate it. There's also an opportunity to address the lack of standardization in education, such as by establishing a national task group to create guidelines on core competencies and workplace safety for care providers.

Finally, there's data. Data is how we make informed decisions. It's as much a resource as physical infrastructure, yet when it comes to national-level data, we struggle. There is no standardized national definition of “the health care industry”, and when it comes to workplace injury data, each province's workers' compensation board codes workplace injury data differently. That makes it difficult to do an apples-to-apples comparison of the data and identify national trends.

In this challenge lies opportunity again, such as taking a leadership role to create a national-level workplace safety data benchmark, as was done similarly in previous pan-Canadian projects such as the Canadian medication incident reporting and prevention system.

Understaffed, under-resourced and under pressure—there's no doubt that these are big challenges, but there is an opportunity for the federal government to drive positive change, and change we must. The future of the health care system depends on its people. If we don't take care of the care providers, who's going to take care of us and our loved ones when we need it?

Thank you.

● (1610)

The Chair: Thank you very much.

Now we go to the Canadian Union of Public Employees and Jenna Brookfield. You have 10 minutes.

Ms. Jenna Brookfield (Health and Safety Representative, Canadian Union of Public Employees): Good afternoon, and thank you for the opportunity to address your committee today.

I speak on behalf of the 680,000 members of the Canadian Union of Public Employees. Our members are on the front line of the health care system, and as such are personally dealing with the phenomenon of workplace violence. Of our members, 158,000 work in health care environments, including hospitals, public health, residential long-term care facilities, community health, home care and the Canadian Blood Services.

Our written submission contains many statistics that help illustrate the prevalence of violence in our health care system. I hope to spend my time here today highlighting the impact on our health care system and on the individual workers that Canadians count on in their times of greatest need.

Almost 1,700 years ago, the Roman poet Juvenal famously asked, “Who watches the watchmen?”, a question that helped articulate the fears of a society concerned with the abuse of power and centralization of that power. If there were a Canadian equivalent to that question in 2019, it would be “Who cares for the caregivers?”

As a society, we have decided that health care is a priority and we've dedicated many resources to its provision, yet we have failed to tend to the needs of those who are on the front lines providing those essential services.

Employers have failed to take appropriate actions to address workplace violence. Provincial governments have failed to appropriately regulate and fund our health care workplaces to address these challenges. Our judicial system has failed to introduce accountability for those who assault our careworkers.

Who cares for the caregivers? Their families do, and so do the unions, but most importantly, the countless Canadians who look to them every day for help and support care deeply for our caregivers in this society. We need to make sure that they feel those in power care as well.

Violence in our health care system is reaching epidemic levels, and that is not just hyperbole. The statistics from workers' compensation boards in all Canadian jurisdictions attest to the fact that workers in long-term care settings alone report more incidents of violence than any other workplaces. A care worker in a long-term care setting is more likely to experience violence on any given day than a police officer or a prison guard.

I wish I could say that now is the time to act, but sadly, that moment passed long ago. Now is the time we can try to limit the damage and do what we can to protect those workers who care for us.

My role at CUPE brings me into contact with care workers every day when their workplace health and safety system fails to protect them and the judicial system fails to hold their assailants accountable and they turn to their unions for support. I am not able to provide the resources they need to be safe at work and I am not able to impose sanctions on those who have assaulted them, but I am able to advocate for them, and that is why I'm here today.

I am here to give voice to our members working in the home care sector who have been beaten and sexually assaulted because when this female-dominated workforce is sent into the homes of their clients, they have no control over their working environment and have no colleagues to turn to when things go wrong. I have met these people. Just last month, I spent an afternoon listening to one of our members who was sexually assaulted at work and didn't want to report it because the last time it happened, nothing happened, except that she had one less client the next day and four hours' less pay.

I'm here to speak on behalf of our members in long-term care workplaces across this country, those workers who strive to provide safety and dignity to a generation of Canadians who built much of what we all enjoy today. Unfortunately, these workplaces have changed dramatically in recent years.

What we used to refer to as “retirement homes” now house everybody who needs care but does not fit anywhere else within our health system. That includes people like a former bodybuilder who suffered a traumatic brain injury and is now unable to regulate and control his violent impulses. This is a real resident in a real long-term care facility. I have personally witnessed the aftermath of his assaults every time adequate staffing resources are not available when he needs care. The lucky ones only have bruises. Three workers over the last two years who have worked with this resident have had bones broken.

It is not just the young and physically vigorous residents who are a source of violence. Rates of cognitive impairments in the elderly are on the rise, and many, such as Alzheimer's or dementia, can compromise the residents' ability to regulate their own behaviour. Through no fault of their own, these residents have also become a frequent source of workplace violence. A lack of resources puts staff at these facilities at risk, as well as the other residents in care.

● (1615)

I'm here to advocate for our members in the acute care sector: the workers in hospitals who provide care to us in our moments of greatest need and all of those who keep these services running, including everyone from the dietary workers in the kitchen to the administrative workers and the environmental service workers who keep our hospitals sanitary and safe from pathogens and bacteria. They are all suffering from violence in their workplaces.

Our hospitals are difficult workplaces at the best of times, but when violence occurs, it makes this difficult work almost untenable. Employees in almost every other sector can pause work in dangerous situations by using the right to refuse unsafe work. This system has broken down in the acute care sector. Licensed staff are threatened that to pause care in any situation could be construed as abuse and cost them their licences and their livelihood. Others are compelled by their empathy to put themselves at risk because someone else is in need.

While other workplaces can bar people with a history of violent behaviour from entering, hospitals must accept everybody and find some way to provide care to anyone who is in need. Our members would be the first persons to advocate for the right of everyone in Canada to receive quality care. CUPE advocates for the right to be safe while providing that care.

The factors causing violence in our health care system are complex and multi-faceted. Researchers have identified four distinct types of workplace violence, and each one is truly a unique workplace hazard that requires a different approach to solve.

What is known as type I workplace violence occurs through criminal acts. Legislative changes such as those proposed in Bill C-434 will help deter some of these events. I would implore the committee to not stop there and to also turn its attention to other forms of violence that plague our health care workplaces.

What the researchers refer to as type II workplace violence is caused when those whom the workplace provides services to become the source of violence. It is incredibly complex in a health care setting. This risk is increased by heavy workloads, staff shortages and a lack of adequately trained security professionals fully integrated in the care teams.

The federal government has the ability to help address these challenges through specific targeted funding as part of the Canada health transfer. Such targeted funding could be earmarked to increase staffing levels and ensure replacements for staff who are sick or injured to ensure that nobody works alone. We could expand health services so that specialized treatment facilities are available and patients are not kept in settings that don't meet their needs or that don't have the training and infrastructure to provide care safely.

Other recommendations on what targeted funding could achieve include the provision of comprehensive in-person training for all staff to better equip them to recognize the signs or conditions that might lead to violence, as well as training on how workers can de-escalate violence and protect themselves if attacked. We can provide front-line workers with personal alarms and ensure that other stationary alarms in the facilities are available and functional, which is not always the case.

Also, we can provide support for workers who have been injured and/or traumatized, such as counselling services, and allow adequate time away from work to recover from an incident. We can provide province-wide access to chart information to inform staff of previous behaviours in patients who have been transferred between facilities, because in many provinces this is not the case.

As well, we can increase the provision of one-to-one care. We can also provide therapeutic programs to reduce patient stress, fear, frustration, boredom and anger. We can increase security personnel with high levels of training and the capacity to intervene with violent individuals.

Our written submission highlights these and other specific recommendations on how the federal government can take practical steps to reduce the risk of violence in health care facilities.

I thank the committee for inviting us to speak today. We look forward to further opportunities to help care for the caregivers in our society.

● (1620)

The Chair: Thank you very much. We're certainly hearing your words.

Now we'll go to the Hospital Employees' Union by video conference for 10 minutes.

Ms. Georgina Hackett (Director, Occupational Health and Safety, Hospital Employees' Union): Thank you to the committee for this opportunity.

My name is Georgina Hackett. I'm the director of health and safety for the Hospital Employees' Union.

Mr. Alex Imperial (Representative, Hospital Employees' Union): My name is Alex Imperial from HEU.

HEU is the oldest health care union in British Columbia and represents 50,000 members working for public, non-profit and private employers. HEU members work in all areas of the health care system, providing both direct and non-direct care services: acute care hospitals, residential care facilities, community group homes, outpatient clinics, medical labs, community social services and first nation health agencies.

Workplace violence is a widespread problem in the health care industry. Violence affects workers in all occupations and settings across the sector. Our care aides frequently experience violence in the workplace, witness and respond to violent incidents and often face threats and intimidation. While physical injuries are of significant concern, the psychological toll of workplace trauma is an emerging issue for our members.

Health care workers now have the highest injury rate of any sector in the province. In long-term care, the injury rate is four times higher than the provincial average. In B.C., according to WCB statistics, health care assistants suffer more injuries than workers in any other occupation and have the highest rate of injuries from violence. They accounted for approximately 16,000 injuries with time lost from work in the past five years, 15% of which was related to violence.

We also know that in health care the compensated claims under-represent the problem. There are multiple independent systems that collect reports of violence from health care workers across B.C. Without a standard integrated system to collect and analyze data, it is impossible to truly estimate the incidents of violence. Lack of centralized information also challenges efforts to identify and address contributing factors for violence that are shared or driven by the system. Research supports our belief that, for a variety of reasons, under-reporting is widespread across the sector. A national strategy or approach for standardized data collection and reporting of violence is recommended.

Our members experience various forms of violence along a spectrum from verbal abuse and threats to physical and sexual assault from patients, residents, clients and even family members. Our members are slapped, kicked, punched, pushed, spat at and grabbed. They endure being yelled at and threatened. These forms of violence result in emotional, physical and financial hardship for our members and their families.

I'm going to give the committee an example of one care aide who was kicked in the face, which resulted in a broken jaw. The trauma resulted in PTSD and chronic pain. The member was off work for a year while on workers' compensation. She is now back at work but is earning less than what she was earning prior to the injury. She is now battling the WCB, which refuses to pay a fair permanent disability claim. Currently, she still experiences dizziness, pain and confusion.

What are the effects of violence in the workplace on our members?

The first is the loss of income. Even if they qualify for workers' compensation or LTD, it will not make them whole, as the WCB will pay only 90% of net; and for LTD, in most cases, will pay only 70%.

Second, they are never the same. Sometimes injuries result in permanent physical and psychological disabilities. Access to treatment can be an issue. They will suffer through pain, anxiety, depression and fear for the rest of their lives, and WCB and LTD will be financially responsible only up to age 65.

Third, violence results in the social isolation of members who are unable to return to their pre-injury job—more so if members are unable to go back to any kind of work at all. We note that some of our members have limited skills and experience to adapt to another occupation. The satisfaction and the connection provided by work and co-workers is gone, the future is uncertain and members need to reinvent their lives to manage, sometimes without success.

Fourth, violence impacts our members' families, which end up providing support both financially and emotionally. In some cases, the effects of the injuries due to violence result in relationship breakdown. Life is disrupted not only for the victim of violence, but also for the family and loved ones.

● (1625)

Ms. Georgina Hackett: The causes of violence in the workplace are complex and shaped by factors across our social, health care and organizational systems when all of these are brought together in the context of care. Solutions require collaborative systems-based approaches involving organizations at all levels of government. For the purpose of this presentation, I will focus on residential care; however, these issues are also experienced in our acute care and community care settings.

Our members report working chronically understaffed and facing crushing workloads to provide the quality care their residents deserve. Working quickly through care routines, with limited flexibility for providing basics such as baths or helping a resident to the toilet, are examples of factors that contribute to the potential for aggressive behaviour and violent incidents.

Our members also see a reduction in the resources to provide their residents with social, cultural and recreational activities, such as music and outings, which would support a meaningful quality of life and alleviate challenging behaviours arising out of confusion, isolation, frustration and boredom.

Our members also note that family members who are frustrated with care delivery or staffing changes due to shortages can also contribute to the potential for violence. They report having to manage the distress of family members who are frustrated, angry and exhausted when they're unable to continue caregiving on their own, encounter challenges accessing home and health care supports and fear having to accept the first available bed in a facility apart from their partner, family support system and their established social communities.

The B.C. seniors advocate reports that almost 85% of the residential care facilities in British Columbia are understaffed compared to the guidelines that have been put in place by the province. Residential home and community care services must expand to meet the growing needs of Canadian seniors and their families. Increasing staffing of both direct and support staff to meet or exceed the minimum staffing guidelines is critical. Residents in long-term care are increasingly frail, and their needs are rising. Ensuring that staffing guidelines keep pace with those needs is essential.

Investment in building infrastructure, violence prevention programs and education is also required. Our members talk about the physical environment being poorly suited to the care needs of residents today and point to a connection between design and violence risks. They talk about their residents needing safe and secure environments that eliminate barriers to mobility, look more familiar than institutional, increase engagement and reduce confusion and disorientation. They also identify the importance of staff safety features, such as clear lines of sight, spaces with multiple exits and the equipment to reliably call for help in emergency situations.

In our members' experience, better strategies are necessary to ensure violence alerts and effective behavioural care plans are implemented and shared across the system, comprehensive risk assessments are done, and “code white” teams are well trained. In addition, they also highlight a need for comprehensive violence prevention education that is available in multiple languages, is specific to their residents' care needs, such as dementia care and mental health, and includes support for practical application, such as peer coaching.

Our members have the right to work in a safe workplace. It's imperative that strong action be taken to establish and maintain safe and healthy workplaces that support a high quality of care.

Thank you.

● (1630)

The Chair: Thank you very much.

Now we go to Liberty Defense Holdings, with William Riker, Jr.

Mr. William Riker Jr. (Chief Executive Officer, Liberty Defense Holdings Ltd): Chairman Casey and members of the committee, thank you for inviting me here today to discuss this very important topic.

My name's Bill Riker and I've spent the last 37 years of my career leading global defence, aerospace and security companies in the implementation of their programs, products and services. This has included roles in general management, business development, product development and engineering and operations. I'm currently the CEO of Vancouver-based Liberty Defense Holdings Ltd., a publicly traded company listed on the Toronto Venture Exchange under the symbol SCAN. We are developing a weapons-detection technology called HEXWAVE that uses active 3-D imaging and artificial intelligence to detect threats in high-volume foot-traffic areas and other urban security environments.

Prior to joining Liberty Defense in August 2018, I served in senior leadership positions with Smiths Detection, a leader in technology for weapons detection, including chemical, radiological, nuclear and explosive threats for the global security market in aviation, military, critical infrastructure and ports and borders. While at Smiths, I became acutely aware of the evolving threat to our communities from violent mass attacks and the need for the means to proactively intervene before they escalate.

I will tell you a little bit about my background. I'm also an Engineering graduate of the United States Military Academy at West Point and I served in the U.S. Army for over 20 years. While serving in Europe, the Middle East and Asia, I became aware of how rapidly violence can escalate and its impact on people's lives. The work that I do now is focused on preventing civilian casualties in places that should be safe and free from fear.

I understand that this committee is focused on identifying ways to improve the security of the health care sector, but the root of the problem is a much larger one affecting not only health care facilities but also schools, places of worship and many other public places. Much has been done over the past 20 years to harden facilities like airports, but there are still many soft targets, such as hospitals, that remain vulnerable to attack.

Our company's mission is to help protect communities and to preserve peace of mind through superior security detection solutions. Our product, HEXWAVE, will be capable of providing accurate, high throughput screening to identify threats. It can be installed covertly or overtly and uses 3-D imaging and artificial intelligence to detect threats in real time. These include both metallic and non-metallic items, in indoor and outdoor environments, in a variety of weather and extreme temperature conditions. The intent of the system is to provide improved situational awareness on a wider perimeter to enable greater response time for security teams.

The technology behind HEXWAVE was developed by the Massachusetts Institute of Technology Lincoln Laboratory in Boston, Massachusetts. We are now in the process of commercializing the technology for deployment in urban security environments starting in the second half of 2020. With regard to hospitals, the challenge is complex, and while there is no single silver bullet solution to counter mass public attacks, the path to preventing such tragedies that have occurred begins with acknowledging the crisis and the variables that contribute to threat events and actively working across government and industry interests to deploy an integrated multisystem approach.

This all starts with awareness. If there's one thing I've learned throughout my nearly four decades in this industry, it's that we don't realize just how dear true peace of mind is until it's taken away.

In October 2014, a mentally ill patient stabbed a nurse multiple times in the head and neck at the Brockville Mental Health Centre in Ontario leaving her seriously injured. Between October 2016 and October 2018, there were 175 violent incidents reported at the Grace Hospital and 444 at the Health Sciences Centre according to data from the Winnipeg Regional Health Authority.

According to Statistics Canada, 34% of nurses have reported being physically assaulted by a patient, and more than 800 health care workers in Ontario have had to miss work due to violence on the job over the past year.

In British Columbia, where our corporate headquarters is located, claims related to acts of workplace violence have been steadily increasing over the past six years, and assaults on nurses, including aides and health care assistants, accounted for more than 40% of all violence-related injuries according to WorkSafeBC.

● (1635)

Violence is the fourth-highest cause of injury within health care. Across all industries, nurses, aides, orderlies and patient service associates suffer the most injuries from violence, according to the Saskatchewan Workers' Compensation Board.

Incidents like these are becoming more common across the health care spectrum in Canada, including in acute care, long-term care and community care. When you consider that this activity is happening in the places where we go to heal, and that these facilities are where we and our loved ones are at our most vulnerable in every sense of the word, these are places where we should feel safe and where peace of mind is most necessary.

Now, it is an unfortunate yet undisputed truth that places such as hospitals, schools, houses of worship and malls are becoming targets. These are places where the public congregates, and they are becoming increasingly susceptible to potential violent events.

This is why I believe we need to change the way we protect these places and to take proactive measures, including embracing new technologies to assist in both detecting and deterring threats at the earliest opportunity, and understanding the limitations of current technologies; maximizing the time security teams and victims have to react by ensuring proactive detection, preferably outside of the soft target or facility; and, last, focusing on widening the threat detection range by implementing a layered approach to provide situational awareness to security teams.

The ultimate goal is to have a proactive rather than reactive strategy of prevention, so that an attack can be intercepted before it occurs. I'm not implying that detection is the only area that needs attention. Certainly not, especially in trying to address these issues, but it is, however, an important part of the equation.

Thank you again for the opportunity to appear before this committee today. I'm happy to answer any questions you may have.

The Chair: Thanks very much to all of you for your opening remarks.

Now we're going to go to our seven-minute round of questions. We'll start with Ms. Sidhu.

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

Thanks to all of you for being here.

My question is for William Riker.

The committee witnesses who appeared before you highlighted the importance of having a robust security protocol surveillance system. You've stated that violence is the fourth-highest cause of injuries in health care and that we need to take a proactive approach. What kind of proactive approach should we take?

Mr. William Riker Jr.: Well, this is a multi-faceted challenge we we are facing. First of all, it's about understanding and accepting the fact that there is the potential for violence in health care settings, especially because of the magnitude of the emotion and activity that's going on there, and especially when you have a cadre of workers who are so dedicated to their patients—they want to help.

In addition to that awareness, then, is understanding what the potential threats are. Right now, our facilities are very open, and clearly we don't want to have a militaristic sort of protection environment, but there has to be something different from what there is now, just because of the prevalence of weapons and how they're proliferating across our society.

A proactive approach very much means to deploy detection systems early at entrances for pre-screening and then having a final screen for actually going into a facility, thereby enabling facilities to isolate any types of incidents. Also, it enables the proper training for guards and staff to be able to respond effectively within a very brief period of time. For example, if there were a shooting or if there were someone who came in with a knife, they would essentially be prevented from entering the facility, so that when emotions are running high, and an event could potentially escalate, that weapon is not present in the facility.

Ms. Sonia Sidhu: What kind of training do you think should be provided?

● (1640)

Mr. William Riker Jr.: Well, the training could very much be multi-faceted, from the perspective that it's clearly, first of all, about awareness and conducting the screening activity all the way through to when an event does occur. How do you isolate people and close the patients and other staff into rooms so that they don't have to try to intercede themselves? At the same time, you try to talk people down out of an incident or, if you have to, you can intervene physically and do that in an effective way and not make more problems than there could potentially be by brandishing weapons and escalating to a subsequent shooting event.

Ms. Sonia Sidhu: Thank you.

My next question is for the Canadian Association for Long Term Care.

Jennifer, you talked about “dementia-friendly environments”. Can you explain that?

Ms. Jennifer Lyle: Sure. When we think about the design of a care home or a care environment, what we're talking about is how the built environment is shaped. I'll give an example pulling from your hallway. It's nice and clean and has great lines. It's awful for somebody with dementia. The surfaces are hard; there's lots of reflection and glare, and there's not a lot of contrast between the walls and the floor. If you put somebody who has a cognitive impairment in that environment, they will become disoriented. They may not know where they are. They'll have trouble finding their way out. I'm a grown adult and I'm going to have to look at my way-finding cues to find my way out. That's how design can look when it's not supportive.

When we talk about dementia-friendly, what we mean is engineering the built environment such that it supports somebody who has difficulty hearing, who may have difficulty with vision or who has difficulty with information processing because their brain has changed, so that they can navigate that environment and interact with it successfully.

A great example of that in care homes is that in the new designs, you don't have dead-end hallways. If somebody has dementia and hits a dead end and they're trying to get out the door, that can lead really quickly to a feeling of angst, anxiety, stress, or anger, so what you see in the newer care homes now are circular hallways so people can have a continuous path instead of hitting a dead end. That's just one example of many, but you can see in that example how that translates directly to the safety of the care providers because they're not dealing with somebody who's upset or angry because they found that dead-end exit.

Ms. Sonia Sidhu: The committee has heard from witnesses about workplace factors, including staffing levels, wait times for health care services, overcrowding and a weak security protocol. How can we address those factors?

Ms. Jennifer Lyle: This is a really big subject, so I'll try to distill it down.

Let's take staffing shortages as an example. Again, I go back to our survey results. When we were looking at how staffing shortages impact workplace safety, we heard very clearly from people that they're rushing to get the task done. I think you actually heard from a number of people about the time pressure they feel that they are under when they're working in that chronically short-staffed situation.

When you're working with somebody who has a cognitive impairment, sometimes you need to stop. You need to pause. You need to take time, but if you're in a situation in which you feel you don't have that time or you don't have somebody you can call in to support you in a certain situation, you could potentially be proceeding with an unsafe situation. Effectively, we set you up to fail right from the get-go as a care provider. That's the piece around staffing shortages.

I also don't want to lose sight of the fact that it's a vicious circle. We talk about workplace staffing shortages creating injuries. I mentioned earlier in my remarks that 650 full-time equivalents had been lost. That was the number of work days lost last year in B.C. just because of workplace injuries. Again, it's the vicious cycle that we get into with regard to that. I think the staffing piece is critical.

The education piece is also critical. You heard from several other presenters about the importance of having education on how to approach a situation and how to de-escalate it if it gets to that. That, absolutely, is a core part of what we do at SafeCare BC. But I also think, to go back to my earlier remarks, that having that education available to people before they hit their first practicum is absolutely critical, because by the time you walk in the front door, if you haven't had that education already from the get-go, you're already behind the eight ball.

The Chair: Now we go to Mr. Webber.

I understand that you're going to split your time with Mr. Lobb. Does he know that?

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Yes, he does.

Mr. Len Webber (Calgary Confederation, CPC): I didn't know that, but I guess the Chair did. I'll be quick then. Thank you, Mr. Chair.

Thank you, everyone, for being here today.

I have the Canadian Union of Public Employees submission here, so I'm going to pick on you, Jenna Brookfield.

Your submission indicates that you're the largest union in Canada with 680,000 members across the country, and that of that, 158,000 are health care members. You have a list of recommendations here. One is that the federal government can prevent violence by providing new targeted funding in certain areas. One area is increased staffing levels—which was mentioned here today by a number of our witnesses—to ensure that no one works alone.

With 158,000 health care workers in the union, if staffing levels were increased, what do you picture that number as then being? What number would be a good, sufficient number to increase to from 158,000?

● (1645)

Ms. Jenna Brookfield: I think that number has to start with the needs of our patients, residents and clients who are in the health care system. I don't think anyone knows of an arbitrary number that we could impose Canada-wide across the system that would fix all of the issues.

The challenge is that the funding that's in place currently doesn't have any bottom built in for staffing levels. Some provinces establish, for example, the number of hours of care that a resident receives in a day. That varies greatly across the country. We have a lack of standardization. It makes it very difficult to make an apples-to-apples comparison from one province to another. I think the staffing levels need to be assessed on a facility-by-facility basis, particularly with an eye to the needs of the residents, clients and patients who are within that facility. Arguably, there will be those in our system who need more care than others. That depends on their age, how ambulatory they are and the medications they're on.

Current legislative frameworks province by province do establish some thresholds for, just as an example, how many registered staff need to be present. That does start to create a bit of a framework for how many people are actually in the facility, but when it comes down to the number of care aides, for example, who are in a facility, there is no standard anywhere in this country other than the number of hours of service that a resident receives. Because of the way we're allocating the existing staff, we're at times increasing the risk by having people working alone. Simply reallocating existing time resources, with an eye to the needs of the facility and the residents, could help to ensure that the workers and residents are safer before we even put another person into the system.

Mr. Len Webber: I see. Great. Thank you.

You also mentioned that the system should replace workers who call in sick. How common is it that they're not replaced? It surprises me.

Ms. Jenna Brookfield: It surprised me too when I came to work for CUPE, but it is a shocking reality across the health system. The practices do differ from one province to another. One factor that influences this is the way in which the licensing of facilities works by provincial health departments. Often the licensing approval is based off the scheduled shifts, not the actual hours worked. The facilities are funded for a base level of care provided in terms of the number of hours.

We've seen many instances of where sick calls have not seen the worker replaced, or even where employers have put policies in place saying they will not replace the first one or two sick calls on a specific unit. Ostensibly, when they do that, they believe they're offsetting the overtime costs they incur in other places, but the end result is that we very regularly have people working short-staffed in care facilities. There's no effort being made to replace them. Too, it's not always a matter of the employer being unwilling to do it. The availability of staff in the sector is also a problem. The recruiting strategies that we have are not sufficient to provide enough people into our system to make sure that the facilities have enough people on their casual and part-time list to pick up the slack when facilities are short.

Mr. Len Webber: Okay.

Mr. Chair, I know I have to share my time. How much time is left?

The Chair: Two minutes and 15 seconds.

Mr. Len Webber: Oh, boy.

Okay, Ben.

Mr. Ben Lobb (Huron—Bruce, CPC): Thanks.

I won't hear any more critiques about equalization from an Alberta MP with that time allocation.

Voices: Oh, oh!

Mr. Ben Lobb: My question is for you, Mr. Riker. Dr. Eyolfson was an emergency room doctor for many years in Winnipeg, I think in downtown Winnipeg. Let's say a distraught person came walking in with a switchblade because they weren't happy with the care they received the night before. Would your system detect that, and what could it do to prevent a doctor or nurse from getting injured?

● (1650)

Mr. William Riker Jr.: A key factor here in the intervention and capture or identification of a weapon before someone comes into a facility is really acknowledging what the spectrum of potential weapons could be. You have to be able to understand what they could be, such as metallic or non-metallic. A switchblade would be an example of a clearly metallic weapon.

The bigger concern is where we are seeing a lot of trends going right now, and that's to ceramic or composite-type weapons. There's the advent of the additive manufacturing gun. That's coming into play now. It's sad to say, but that's the reality. Perhaps of special concern is any kind of explosive or that type of substance coming in. It doesn't take an awful lot.

Mr. Ben Lobb: Your system would detect it, and then what would it do—lock the doors? What could it possibly do?

Mr. William Riker Jr.: In the detection sequence, first is the identification of a potential threatening item on a person or not, because part of the system here is that it will allow non-threatening weapons or articles to go into the facility. But if it does identify an issue, then there's an alert to the security guards, or it can also physically interact with the lock-out system of the doors. It can essentially lock the doors before the person gets into the facility.

When you look at the hospital configuration right now, you essentially have the four A's established out there. The fact that this system can be deployed on the outside of the building or on the pathway enables you to get that early detection, prevent the entry from occurring, and go ahead and give the security organizations or teams time to respond.

The Chair: I'm sorry, but your time's up, Mr. Lobb. You can blame Mr. Webber.

Now we go to Ms. Kwan.

Ms. Jenny Kwan (Vancouver East, NDP): Thank you to all the witnesses for their presentations.

I want to first acknowledge and say thank you to the health care workers in our system from CUPE, HEU, and also the Canadian Association for Long Term Care, and to those who are not around this table. You do tremendous work in our community each and every day. It's fair enough to say that every worker deserves to go to a safe work environment, and this is what we're talking about.

I think all of the presenters talked about a standardized level of care that is needed across the country. Related to that is a standardized level of safety and how we implement that from the federal government's side. How do we go about ensuring that all the provinces have the mechanisms in place for, for example, staffing ratios?

I'll start with you, Ms. Lyle, and then go to Ms. Brookfield and then I'll come to the folks on the screen.

If you can, just list some examples of where you think the federal government should take action in bringing in a national strategy. Data collection was one thing I heard about. Are there other items that you think are a priority that the federal government needs to act on?

Ms. Jennifer Lyle: Yes. I'll go back to my earlier remarks about the health human resource strategy. If I remember correctly, the last strategy was originally authored in 2004. We're 2019 now. I would say that 15 years down the road we've seen again that shift towards the community-based care. We've also seen a rising level of awareness around not just the physical safety of staff—it was mentioned a few times in the other presentations—but also the psychological well-being of staff. I think one thing is to look at that national health human resource strategy and to revise and reinvigorate it with those aspects in mind, again taking into account the physical and psychological well-being of the care providers, relating the intersection between workplace safety and health human resources. Finally, the strategy needs to be revised with an eye to the fact that we deliver care in a community-based setting now more than ever. That's the model we're heading forward with, so I would say that would certainly be one, in addition to the data piece.

There's one last piece I would throw out there for consideration. A lot of the stuff we struggle with has to do with lack of awareness. We need to look at the opportunities for public-facing campaigns on the risks of violence in health care, and not just the risks but also the strategies and the opportunities that we can take advantage of to mitigate that risk. I think that is potentially an area where the federal government can take a role as well.

Ms. Jenny Kwan: Thank you very much.

Ms. Brookfield.

Ms. Jenna Brookfield: Jennifer made some wonderful points on the human resource side of things. There's one point I would add: We need to have a national strategy on getting people into these professions and retaining them there as well.

The retention is a really key point today. I've seen efforts in multiple provinces to recruit, but we're losing them on the retention side, and we do that for all of the reasons we've discussed here today. We're not making it a very welcoming work environment in terms of both the physical and psychological strains of the job and the lack of support that people feel, not just from their employers, but from the society as a whole. That's one point that I really wanted to get across. A lot of care workers feel like they're toiling in obscurity.

They are doing something that we terribly need them to do. I imagine that everyone in this room has had or has someone we love in a hospital—if not ourselves—or in a long-term care facility. We think a lot about them and their needs, but we need to focus on who cares for the caregivers in our society. There does need to be a strategy on recruiting and retaining people by developing a culture of valuing the health care worker.

That is part of a recruitment strategy, but it also comes to the second point, which is outside of the human resources side of things: how we actually fund and run the facilities. We do need more standardization across this country. I know that very clearly there's a division of powers between the federal and the provincial governments; however, the federal government provides the bulk of the financial resources that keep our health system up and running.

There are countless examples of where the federal government funds things that are constitutionally under provincial jurisdiction and does provide benchmarks or earmarked funding for certain priorities. We could have a national standard for the level of care that's appropriate in an acute care setting, in a home care setting or in a long-term care setting. That could be based on the number of care hours that a client receives. That also could be based on the population size and the needs of those individual provinces.

I think we need to look both at the human resource side and at the facilities themselves, because our recruitment and retention strategy is not going to work unless we're actually making efforts to improve the working conditions across our health care sector.

● (1655)

Ms. Jenny Kwan: Thank you very much, Ms. Brookfield.

We'll go to the video conferencing with the HEU representatives. I don't know who's going to take this one on.

Is it Ms. Hackett?

Ms. Georgina Hackett: Yes.

To build on some of the things we've already talked about around data collection, reporting and ensuring that we are working towards understanding what the whole picture looks like, the data that we've reported out and discussed today is largely related to compensated claims. We know that there's a lot more information out there in the system that would help to inform how the system impacts violence in the workplace.

Some of that might lead to better nationwide strategies around providing people with social supports and family supports, as well as accessing and navigating the system, all of which contribute to the stressors that family members and patients are experiencing.

Another opportunity is that of creating national standards around the built environment specific to facilities by looking at those standards and expanding them or improving them around dementia care to make them dementia friendly.

Last, we would also support the ideas that have already been mentioned around human resources recruitment and retention. Those are challenges that we consistently see in British Columbia as well.

The Chair: Now we'll go to Mr. Ouellette.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much for coming, everyone.

I want to talk a bit more about dementia and dementia-friendly environments, which you talked about, Jennifer. How much research has actually been done on how the physical layout impacts whether there is violence by patients who have dementia and on improving safety? Is there a lot of research on that?

Ms. Jennifer Lyle: It's a bit of a tricky one. To answer your question on research into how the built environment impacts the behaviour of folks with dementia, that's been done. There's a growing body of it out there that's currently available and looks at the intersection between behaviour and the built environment.

Where it gets a bit trickier—and I think you've actually hit on a weakness that we see across the board—is that there's a lack of research that makes that second leap, looking towards the tie-back with built environment and the actual hard data on workplace injury rates. We can make a secondary leap by saying that fewer responsive behaviours equal fewer incidents of violence, but actually making that direct leap is a bit tricky.

I would say that we can have the same problem when we run into the research looking at models of care. There's a growing body of research that looks at how different models of care impact the quality of the client or patient experience, but how that impacts the workplace safety of the care providers is often a component that's missing. This is actually a piece that we recently went into provincially—just because the body of research is a bit thin on that side—in looking at whether or not the person-centred care model, which is associated with stronger quality of care outcomes for dementia care clients, actually translates into fewer incidents of violence.

● (1700)

Mr. Robert-Falcon Ouellette: However, a lot of the old facilities, for instance, have very long corridors, and there's a little nerve centre down at the far end, which means it is very difficult sometimes in these long-term care facilities to get help. Is that a model that is encouraged, or is that just because the layout has just been like that and we haven't really built anything different?

Ms. Jennifer Lyle: It's definitely the latter; it's more a historical precedent. If you look at the best practices right now, there are some great organizations in B.C. that have incorporated good design. You don't see those long dead-end hallways. You don't see walking paths that terminate at a door. You do see things like visual way-finding cues like memento boxes outside of people's rooms. You see doors painted different colours so a resident knows which room is theirs. You see walking paths. You see access to activities that you can do spontaneously to combat issues of boredom.

Mr. Robert-Falcon Ouellette: How much of this information is shared with all health care providers in these long-term care facilities? I've been in a number in Winnipeg Centre and I didn't see coloured doors. I saw everything had white walls and maybe a kind of greenish hue on the doors. How much of this information about best practices is shared among health care facilities?

Ms. Jennifer Lyle: I can't necessarily speak to all of the provinces. I know that in B.C. a number of initiatives are under way. Creating dementia-friendly care homes is one initiative. It's part of a partnership between B.C. Care, SFU, and I'm forgetting another partner in there, who are looking at that specific translation. That is under way. I think the big challenge people run into is that at the end of the day, infrastructure upgrades cost money and care homes more often than not struggle with that funding. Again I point to the investing in Canada plan, under which it was great to see the investments in the community care piece, but there wasn't anything for care home infrastructure. Again, to put it in crass terms, if you don't have the dollars to make those changes, it's really hard to make it happen.

Mr. Robert-Falcon Ouellette: Thank you very much.

Mr. Riker, I have a few questions for you. You talked a little bit about safety. It was kind of interesting. I haven't heard that conversation very much around this table very much. I was just wondering if you could talk a little bit more about the use of technology not on the outside, perhaps, but even with patients. For instance, is it possible to be able to predict a behaviour of people with dementia in various situations, to monitor blood pressure in real time and to say, oh, something's coming, and maybe we should change what we're doing in this environment in order to keep a reaction lower. Is that possible?

Mr. William Riker Jr.: Yes, you actually have a great point there. There is a breadth of technology available out there for identifying and predicting behaviours. It spans the range from facial recognition to identify certain persons of interest all the way through to seeing behavioural changes—and then from a causality perspective saying, okay, someone is clearly upset, and what's the potential that that person will escalate to another level of violence or anger? That is something that can be be worked into a facility's security or communication system. From an ease-of-use potential opportunity, here is the training that would be proposed, and then of course there would be any kind of alert badges or indicators that staff could have to ask for help when they see something occurring.

Mr. Robert-Falcon Ouellette: How much of this technology is currently being used? Is anyone using any of this technology in any health care setting in Canada? Do people actually have buttons they push for assistance in home care or any other situation?

Mr. William Riker Jr.: From my experience, at this point a lot of this is due to the gun violence that has occurred in the U.S. For example, at the Mayo Clinic last month the CEO reported that 30,000 weapons had been identified within facilities in the U.S. Those are actively captured weapons that were prevented from being introduced into facilities.

An approach has to be able to account for, number one, a staff member alerting that they need help, and, number two, enabling them to have the training to be able to respond to that scenario. Of course, number three is really preventing anything from getting inside the facility. There should be no reason for any type of threat article to make its way into a facility.

● (1705)

Mr. Robert-Falcon Ouellette: Do a lot of employees have access to buttons they can push if they are in home care settings, for instance? Will you talk about that a little bit? Obviously, we're spending $5 billon on home care, $200 million of that in Manitoba. We often think those are very safe environments, but when you're dealing with people, sometimes issues do arise. Do people have the proper security devices to alert others that there is a problem?

Ms. Jenna Brookfield: We are starting to see some technological solutions being integrated into home care, particularly with smart phones and devices being provided by employers. The problem is that they don't give any ready access to help in an urgent situation. Even if the care worker has the ability to call for help, it could be 10 to 20 minutes, or maybe even up to an hour, before the closest colleague could get to them to provide help. The response system ends up becoming the police for the home support workers. Really, we've missed an opportunity there to assess the risk they're being exposed to prior to putting them in there with that button.

The use of panic buttons and alarms is more widespread in the acute care sector. In late 2016 in Nova Scotia, we had someone enter a rural hospital with a firearm. Luckily, nobody was injured in that incident, but it was a bit of a wake-up call for the system.

I had the opportunity to participate on a task force that was making recommendations to the premier of Nova Scotia to improve health and safety and security in the acute care sector. One thing we found out very quickly was that some hospitals had such a system, where there was someone on the front desk who could press a button so that the police knew there was an emergency, and some did not. Some hospitals had systems whereby nurses who might be in a patient's room alone wore a button to hang around their neck in order to be able to call for help when something went wrong, and some did not. One of our recommendations was for standardization of that across our acute care sector.

Mr. Robert-Falcon Ouellette: Was that in the acute care sector across Canada or just within the province?

Ms. Jenna Brookfield: That task force was just mandated to make recommendations to the health minister in Nova Scotia. I know there is a bit of a patchwork across the country. No province that I know of has a standardized application of that kind of technology right across the province.

The Chair: Okay. The time is up.

I want to thank the witnesses for their contributions.

We heard testimony that some home care workers had to leave their phones in their car when they went to a home. Does that sound safe?

Voices: No.

The Chair: I live in rural Nova Scotia. It's all rural, and I know that the home care workers go to little places such as Advocate Harbour all by themselves. It just strikes me that it's not right.

Mr. Riker, would your equipment help an LPN in a car 100 kilometres away from anyplace else?

Mr. William Riker Jr.: No, not necessarily, Mr. Chairman. The key thing is that our system is based on an approach of proactive prevention of a weapon coming into a facility, not in a car or something like that.

The Chair: All right.

I'm going to suspend the meeting for a few minutes because we have to do clause-by-clause on Bill S-248, but I want to thank the witnesses again for their contribution.

You have a very strong message, and we thank all of you for that message.

We'll suspend for two minutes.

● (1705)

(Pause)

● (1710)

The Chair: Ladies and gentlemen of the committee, we are going to do clause-by-clause of Bill S-248. I believe everybody has the bill.

We're going to move right to clause 2. It's very complicated—it's one sentence. Are there any issues with clause 2? Shall clause 2 carry?

(Clause 2 agreed to)

The Chair: Now we're going to move to clause 3. It's another sentence. Shall clause 3 carry?

(Clause 3 agreed to)

The Chair: Shall the short title carry?

Some hon. members: Agreed.

The Chair: Shall the preamble carry?

Some hon. members: Agreed.

The Chair: Shall the title carry?

Some hon. members: Agreed.

The Chair: Shall the bill carry?

Some hon. members: Agreed.

The Chair: Shall the chair report the bill to the House?

Some hon. members: Agreed.

Ms. Jenny Kwan: We'll think about that.

The Chair: No? Is that on division? No.

Some hon. members: Oh, oh!

The Chair: All right, congratulations. We've passed another one.

That's it.

The meeting is adjourned.