College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

FACILITATOR'S GUIDE AND WORKBOOK

ONE is ONE too MANY

Abuse Prevention Program

Updated 2005

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Introduction

Notes

Recent studies have shown that client abuse remains a serious issue in all types of health care settings.[1] Preventing abuse is critical for nursing, and is the responsibility of every nurse. Helping nurses prevent client abuse is part of the College of Nurses of Ontario's legislative role. The College believes that the best way to prevent abuse is to support nurses to practise in accordance with the standards of the profession.

CNO's *One is One Too Many* program was first launched in 1994 as part of a legislative requirement for all health regulatory colleges to provide education about client abuse to members. It focused on helping nurses recognize abuse and developing personal and organizational strategies for abuse prevention. Since 1994, the program has been widely used across Ontario. It has been overwhelmingly praised by clinical educators and practising nurses as an abuse prevention education program that can be used in all types of practice settings and with all staff.

This updated version of the *One is One Too Many* program incorporates material from the *Therapeutic Nurse-Client Relationship, Revised 2006*,[2] practice standard as well as new information from our recent research on client abuse. The video has been updated to include a scenario on financial abuse and more information on how to contact the College. All program materials have been streamlined for improved flow and ease of use. The result is an enhanced adult learning program that explores all aspects of abuse prevention in the context of the therapeutic nurse-client relationship.

This guide can help nurses learn how to prevent, recognize and stop abuse. The learning package includes a video, DVD, workbook and facilitator's guide. In using this learning program, nurses will learn best parctices for interacting with clients and reflect on their own values regarding client care.

Impact of Program on Nurses

One is One Too Many is clearly having an impact on nurses. CNO recently studied (see Appendix 1) the impact of the program and found that:

- 45% of nurses are aware of this program; and,
- 14% of nurses have participated or been exposed to the program.

Nurses exposed to *One is One Too Many* are more likely (than those who have not been exposed to the program) to report an incident of abuse. Nurses who have been exposed to the program recall:

- that there are different forms of abuse;
- that abuse should not be tolerated; and
- how easy it is to abuse the nurse-client relationship.

[1] See Appendix 1, CNO Research into the Abuse of Clients

[2] At the time of printing, the *Therapeutic Nurse-Client Relationship, Revised 2006*, practice standard was in draft format.

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Other Potential Uses for the Program

The *One is One Too Many* program can be used to help meet nurses' annual Quality Assurance requirements. For nurses who feel they need to learn more about the nurse-client relationship and professional boundaries, this program can serve as a useful addition to their annual Reflective Practice learning plan. In arranging a group learning session, ask your nurse colleagues if they are interested in using this program as part of their Reflective Practice requirements.

The College of Nurses of Ontario would like to thank all of the nurses, consumers and health care facilities who generously gave of their time, shared their ideas and provided suggestions to help develop this resource package.

What is Abuse?

Being aware of the different types of client abuse is the first step in preventing it. Abuse is defined in the context of the nurse-client relationship. It is a misuse of power and/or the betrayal of trust, respect or intimacy in the therapeutic relationship. Abuse of a client always interferes with meeting the client's therapeutic needs and may permanently harm the relationship between the nurse and the client. It can occur in any practice setting and result from either deliberate action or indifference.

Knowing the five elements of the nurse-client relationship is a good basis for understanding abuse and its impact on the client. These elements are fully discussed in the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard and form the basis of Learning Module 2.

Examples of Abuse

Abuse can take many forms. Becoming sensitive to these behaviours will help you to identify and prevent abuse. The behaviours listed below are always unacceptable.

Emotional/verbal abuse is a demonstration of disrespect for the client and includes actions such as:

- sarcasm;
- intimidation, including threatening gestures/actions;
- manipulation;
- teasing or taunting;
- insensitivity to a client's preferences;
- swearing;
- cultural slurs; and/or
- an inappropriate tone of voice.

Physical abuse includes behaviours toward a client that are violent, threatening and/or inflict physical harm and includes actions such as:

- hitting;
- pushing;
- slapping;
- pinching;
- shaking;
- using force; and/or
- handling a client in a rough manner.

Sexual Abuse of a client by a member of a regulated health profession is defined specifically in the *Regulated Health Professions Act* (RHPA) as follows:

- sexual intercourse or other forms of physical sexual relations between the member and the patient;
- touching, of a sexual nature, of the patient by the member; or

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- behaviour or remarks of a sexual nature by the member towards the patient.

Nursing, by its nature, includes activities that involve touching or conversations that deal with intimate personal content. Abuse of a sexual nature does not include touching, behaviour or remarks *that are appropriate for the services provided*.

If the nature of the nurse-client relationship is psychotherapeutic or involves intense psycho-social counselling, nurses are prohibited from forming a sexual or romantic relationship with a client or client's significant other until at least one year after the termination of the nurse-client relationship, and only if such a relationship will not have a negative impact on the well-being of the client.

Neglect occurs when a nurse fails to meet the basic needs of the client either deliberately or due to indifference, and includes actions such as the withholding:

- clothing;
- food;
- fluid;
- needed aids or equipment;
- medication;
- communication;
- care;
- privileges; and also includes
- confining, isolating or ignoring the client.

Financial abuse occurs when a nurse takes financial advantage of a client, either intentionally or not, in ways that are either legally or ethically inappropriate, and includes actions such as:

- borrowing money;
- soliciting gifts;
- withholding finances or theft;
- using influence, pressure or coercion to obtain the client's money or property;
- abuse of trusteeship, bank accounts, power of attorney or guardianship; and/or
- assisting with the financial affairs of a client without the health team's knowledge.

Mandatory Reporting Requirements

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The *Regulated Health Professions Act* (RHPA) requires any health professional who has reasonable grounds to believe that a client has been sexually abused by another health professional to report this to the college of the alleged abuser. This requirement applies to information obtained in the course of practising the profession. Reasonable grounds include:

- information received from a normally reliable source, such as another nurse; or
- reports from a patient about a specific incident that occurred to him or her unless it is known the allegation could not be true (e.g., the person was not on duty on the day that the abuse allegedly occurred).

Note: Rumours and gossip do not, by themselves, constitute reasonable grounds.

Mandatory reporting makes the job of facilitating discussion about abuse prevention more difficult. However, it is important for the facilitator to communicate reporting requirements clearly to participants at the beginning of all education sessions. Make it clear that facilitators are obliged to report sexual abuse of a client to the College if it is disclosed by a participant.

If, during a learning session, a participant discloses the sexual abuse of a client, the facilitator must report the abuse to the College.

How To Report Sexual Abuse

If you become aware of information about the sexual abuse of a client by a health professional, you will need to make a report to the College of the alleged abuser. If you have questions about filing a report about a nurse, call the College of Nurses of Ontario at 416 928-0900 or toll-free in Ontario at 1 800 387-5526.

Nurses are not required to investigate or make inquiries to confirm that the allegations are true before reporting. You can make a complaint to the College about abuse(s) without the client's consent. However, in cases of sexual abuse, the client must give permission for his/her name to be used in the complaint.

The report must:

- be filed in writing within 30 days;
- be filed sooner if the person filing the report believes the alleged abuser will continue to abuse the client or abuse others;
- include the name of the person filing the report, the name of the person who is the subject of the report and a description of the alleged sexual abuse; and
- include the name of the client only if the client or the client's substitute decision-maker consents in writing to the inclusion of the client's name.

Nurses are also required under professional misconduct regulations to intervene to prevent abuse by a nurse or another health care provider and to report such incidents to the employer or other authority responsible for the health care provider, and/or to the appropriate college if the provider is a regulated health professional.

How To Use the Learning Modules

All of the modules are structured for 30- to 60-minute sessions. Because the modules are problem-centred and designed to promote self-reflection, we recommend groups of eight to 10. For larger groups, breaking into teams of six to eight will facilitate problem-solving and discussion. Have a spokesperson from each team report on the highlights of the discussion to the larger group.

The learning modules are organized to examine specific issues. Each module identifies:

- the purpose of the module;
- learning outcomes;
- learning activities;
- discussion questions;
- information/explanations to help the facilitator interpret, define or respond to issues; and
- strategies for the prevention of abuse, when appropriate.

Recommended Approach

Ask participants to fill out the Self-Reflection Questionnaire before and after completing the program. (See Supplement 1.)

1. Start with an introductory module that includes the video, an overview of CNO expectations and an opportunity to discuss reactions.
2. Schedule a continuing series of sessions selecting relevant learning activities from the modules. Reinforcement is key to effective learning. A one-time discussion or viewing of the video is less likely to result in permanent learning and behaviour change.
3. Develop ongoing informal ways to promote learning and conversations about therapeutic relationships and abuse prevention. Team meetings, consultations and critical incident debriefings are possible opportunities to reinforce concepts.

Program Options

The learning modules can be organized in a variety of ways.

1. Use the modules individually as a continuing series of education sessions.
2. Use two or more modules to create a half-day education program. Follow up this session with subsequent sessions featuring other modules.
3. Build an all-day education program from the six modules.

Program Combinations

Basic Minimum:

Effective Client Abuse Prevention (three hours)

Modules 1, 2, 8

Recognizing Client Abuse (three hours)

Modules 1, 4, 5, 8

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Prevention of Client and Nurse Abuse (four hours)

Modules 1, 2, 8, 9

The Therapeutic Nurse-Client Relationship (four hours)

Modules 1, 2, 3, 6

Boundaries in the Nurse-Client Relationship (four hours)

Modules 1, 2, 6, 7

Complete Program (eight hours)

Complete all nine modules

Learning Modules Chart

This table summarizes the time and materials required for each module.

	Time	Materials/Equipment
Module 1 **Video/DVD**	• 25:20 minute video viewing time • 30 minutes for discussion	• VCR/DVD player and monitor • *One is One Too Many* video • Evaluation Form (Supplement 2) • Flip chart or overhead projector
Module 2 **The Nurse-Client Relationship**	• 30 to 45 minutes	• *Therapeutic Nurse-Client Relationship, Revised 2006*, practice standard • Flip chart or overhead projector • Evaluation Form (Supplement 2)
Module 3 **Developing Therapeutic Relationships**	• 45 minutes	• *Therapeutic Nurse-Client Relationship, Revised 2006*, practice standard • VCR/DVD player and monitor (optional) • Flip chart or overhead projector • Prepare notes for flip chart/ overhead projector • Evaluation Form (Supplement 2)
Module 4 **Recognizing Physical, Emotional and Verbal Abuse**	• 30 minutes per case	• *One is One Too Many* video • VCR/DVD player and monitor • Evaluation Form (Supplement 2)
Module 5 **Recognizing Sexual Abuse**	• 30 minutes per case	• *One is One Too Many* video • VCR/DVD player and monitor • Evaluation forms (Supplement 2)

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	Time	Materials/Equipment
Module 6 **Boundaries in the Nurse-Client Relationship**	• 45 minutes	• Copies of case study (see below) • *Therapeutic Nurse-Client Relationship, Revised 2006*, practice standard • Evaluation Form (Supplement 2)
Module 7 **Giving and Receiving Gifts**	• 45 minutes	• Copies of case studies • *Therapeutic Nurse-Client Relationship, Revised 2006*, practice standard • Evaluation Form (Supplement 2)
Module 8 **Actions to Stop Abuse**	• 45 minutes	• VCR/DVD player and monitor • *One is One Too Many* video • Flip chart or overhead projector • Prepared notes for flip chart or overhead projector • Evaluation Form (Supplement 2)
Module 9 **Abuse of Nurses**	• 45 minutes	• *Nurse Abuse* practice guideline • Flip chart or overhead projector • Prepared notes for flip chart or overhead projector • Evaluation Form (Supplement 2)

One is One Too Many Video/DVD

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Purpose

To heighten awareness of client abuse by nurses and demonstrate ways of preventing abuse.

Learning Outcomes

- Identify physical, verbal, emotional and sexual abuse.
- Understand the impact of abuse on clients.
- Know how to take action to stop an abuse situation.
- Understand the reporting requirements for health professionals in Ontario.
- Know the personal and environmental risk factors for clients.

Learning Activities

1. Introduce the video by explaining the content and suggesting that if participants have strong reactions during the viewing they can discuss them after the video or leave the session. (See Dealing with Difficulties, page 58.)

2. View video.

3. Discussion questions. (Select from the following, as time permits.)

A. How is your experience in caring for clients the same/different from the experiences depicted in the video/DVD?

B. What is abuse?
(Summarize the definition on the flip chart or overhead.)

Abuse is the misuse of power and/or the betrayal of trust, respect, professional intimacy, or empathy between the nurse and the client which the nurse knew or ought to have known can cause or be reasonable expected to cause physical or emotional harm to the client. This definition includes all types: physical, emotional, verbal and sexual abuse. Neglect and financial abuse also fall under this definition.

Sexual abuse of a client by a member of a regulated health profession is defined specifically in the *Regulated Health Professions Act* (RHPA) as follows:

- sexual intercourse or other forms of physical sexual relations between the member and the patient;
- touching, of a sexual nature, of the patient by the member; or
- behaviour or remarks of a sexual nature by the member toward the patient.

C. What personal factors put nurses at risk of abusing clients?
(Write participants' suggestions on flip chart or overhead.)

A nurse is at increased risk of abusing a client if she/he:

- is or has been abused;
- is experiencing professional burnout or has personal problems that reduce her/his coping ability (e.g., marital or financial problems);

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- lacks insight into personal and culture-specific values and traits that influence her/his own reactions and those of clients;
- disregards clients' rights; and
- has knowledge gaps about how to manage clients who exhibit difficult or aggressive behaviours.

D. What environmental factors increase the risk of client abuse? (Write participants' suggestions on flip chart or overhead.)

Environmental factors that increase the risk of abuse of clients are:

- heavy workload;
- inappropriate nursing skill mix for the client population;
- inadequate staffing and care-delivery models; and
- lack of agency support and caring for the caregivers.

E. What client factors can increase the risk of abuse? (Write participants' suggestions on flip chart or overhead.)

The risk of abuse is increased if the client is:

- elderly;
- confused;
- aggressive;
- combative; and
- considered difficult.

F. What personal and workplace strategies would help prevent the abuse of clients? (Write participants' suggestions on flip chart or overhead.)

Strategies may include:

- know own triggers and risk factors;
- know how to manage clients who demonstrate aggressive behaviour;
- learn about other cultural values;
- learn communication skills;
- peer support activities; and
- obtaining support from management.

G. How can you put these strategies in place? (Write suggestions on flip chart or overhead.)

Possible actions include:

- find a work colleague who you can talk to when you feel frustrated;
- set up team meetings to develop care plans for clients who are difficult to care for;
- identify experts in your organization who you can consult with on managing difficult client situations;
- talk with colleagues about client abuse; and
- advocate for appropriate resources and abuse-related policies in the practice setting.

4. Develop action plans and schedule a follow-up. Suggest that participants pick one strategy from the list to try in the next week.

5. Evaluation by participants. (See Supplement 2.)

The Nurse-Client Relationship

Purpose

To review the standard statements in the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard.

Learning Outcomes

- Develop your understanding of the nurse-client relationship.
- Understand the role of the therapeutic relationship in defining and preventing abuse.

Learning Activities

1. Prior to the session, distribute copies of the standard statements from *Therapeutic Nurse-Client Relationship, Revised 2006*.

2. Ask participants to write a brief statement about what is most important in the nurse-client relationship. (This could also be done prior to the session.)

3. Discuss the following questions:

- How is your statement the same/different from CNO's?
- Are there any questions about what the principles mean?
- What can you do to maintain these principles in your relationships with clients?

Reflection Exercise for Participants

4. Write a brief description (300 words) of a nurse-client interaction that you witnessed that illustrates how nurses honour the following principles of the nurse-client relationship: trust, respect, professional intimacy, empathy and power. Include the following details:

- when it occurred;
- who was involved; and
- what was significant about the incident.

Discuss the responses with the group.

5. Present an example of a nurse-client interaction that did not go well and that illustrates how nurses violated one of the principles of the nurse-client relationship: trust, respect, professional intimacy, empathy and power. Analyze the incident in light of the elements of the therapeutic nurse-client relationship. Participants do not need to share their response with the group.

6. Evaluation Form. (See Supplement 2.)

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Developing Therapeutic Relationships

Purpose

To help nurses improve their understanding of the importance of effective communication with clients and the role of communication in preventing client abuse.

Learning Outcomes

- Understand the impact of communication on building and maintaining the nurse-client relationship.
- Use the nurse-client relationship to enhance quality care.
- Use effective communication to prevent client abuse.
- Be more aware of client's perspectives on nursing care.

Learning Activities

Prior to the session, ask participants to review the section on therapeutic communication in the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard.

Option #1

1. Begin the discussion on communication with clients by sharing a example of successful communication from your practice. Briefly analyze what you see as the strength of your approach in the example and how it might have gone wrong. Use the elements of trust, respect, professional intimacy, empathy and power in your analysis. You may also refer to the section on therapeutic communication and client-centred care in *Therapeutic Nurse-Client Relationship, Revised 2006*.

2. Ask participants to write brief notes about an actual example of good or poor communication with a client, and identify the factors that enhanced or hampered communication.

3. Ask participants to share their experiences and what they felt made it successful, or what could have been better. Do this on a volunteer basis only.

4. Brainstorm ways to improve communication and record suggestions on a flip chart or overhead projector.

Option #2 — Video/DVD

1. Use the video segment "Scott" and/or "Annie" to stimulate discussion of what the nurses could have done to ensure the client was not neglected. (Tape/DVD position: Scott 15:50, Annie 16:45)

2. What went wrong in these scenarios?

Some expected responses include:

Scott:

- no assessment of client care needs;
- no time taken to talk to client;

- no assessment and discussion about why client was not eating;
- did not listen for client's response to questions;
- client was not included in the care plan; and
- nurses too oriented to the task.

Annie:

- approached client without warning and without an introduction;
- nurses approached client simultaneously;
- towering over client (rather than at eye level) is threatening;
- client given no choice about whether she wanted or needed to take a bath;
- no time provided for client to express why she did not want to take a bath;
- reacted to client's behaviour instead of its meaning; and
- began to forcibly undress client.

3. Have an open discussion on ways to improve communication and record the suggestions on a flip chart/overhead projector.

4. How could verbal and non-verbal communication have been more appropriate/effective in this scenario?

Some expected responses include:

Scott:

- ask client about his needs, and include his need for assistance with eating in the care plan;
- listen effectively; and
- assess client condition.

Annie:

- nurses approach the client one at a time;
- when talking to client, nurses position themselves at eye level with the client;
- ask client whether she understands and agrees to take a bath;
- discuss a bath schedule with the client;
- explore reasons for refusing to take a bath; and
- discover when and how often client took a bath prior to admission.

5. Discuss similarities in the responses for promoting good communication. Suggest others from the section on therapeutic communication in *Therapeutic Nurse-Client Relationship, Revised 2006*.

6. How could practice setting resources or systems have prevented or contributed to this situation?

7. After the session, print and distribute the suggestions for improved communication.

8. Evaluation Form. (See Supplement 2.)

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Recognizing Physical, Emotional and Verbal Abuse

Purpose

To increase awareness of subtle forms of physical, emotional and verbal abuse that may occur in nursing practice.

Learning Outcomes

- Understand how the actions of the nurses in the video violate the therapeutic relationship.
- Be able to recognize physical, verbal and emotional abuse.
- Understand why the situations are abusive to the client.
- Be knowledgeable about the factors that contribute to abuse.

Learning Activities

Select one of the three dramatic sequences in the video *One is One Too Many* that illustrate physical, verbal and emotional abuse. Use the accompanying questions to discuss the scenarios.

1. Mrs. Lawrence (Tape/DVD position 13:30)

This sequence features an elderly woman who is portrayed as "difficult." Mrs. Lawrence constantly uses the call bell. On this occasion, the nurse is delayed in responding to the bell because of an emergency. When she answers the bell, the client is very upset. She has wet her bed. The nurse scolds the client and then leaves her to sit in the wet sheets until she has time to change them.

Discussion Questions

What kind of abuse is demonstrated in this scenario?

Examples of possible responses.

Emotional abuse:

- not recognizing that the client is dependent on the nurse to meet basic functional needs; and
- wetting the bed is a humiliating experience.

Neglect:

- leaving her in a wet bed causes the client discomfort and leaves her vulnerable to skin breakdown.

Verbal Abuse:

- chastising the client for wetting the bed.

How did the nurse violate the components of the nurse-client relationship in this scenario?

Some expected responses:

Trust:

- Mrs. Lawrence relied on the nurse to help her meet her basic human needs. She was let down and made to feel even more vulnerable.

Respect:

- Leaving her in a wet bed violated Mrs. Lawrence's dignity.

Professional Intimacy:

- Helping Mrs. Lawrence with her bodily functions is an example of intimacy in the nurse-client relationship, yet the nurse showed neither caring nor sensitivity in dealing with the situation.

Empathy:

- The nurse did not show an understanding of Mrs. Lawrence's vulnerability, discomfort and frustration.

Power:

- Leaving Mrs. Lawrence in the wet bed was an inappropriate use of power.

What factors contributed to the abuse happening?

Some expected responses:

Nurse-related factors:

- just came from a stressful situation; and
- having difficulty coping with Mrs. Lawrence's behaviour.

Environmental factors:

- busy unit with very sick clients.

Client-related factors:

- Mrs. Lawrence is perceived to be a "demanding" client;
- Mrs. Lawrence is perceived as not being that sick in comparison to other clients; and
- elderly woman, unable to help herself.

How do you think the nurse was feeling at the end of the sequence?

Some expected responses:

- angry;
- frustrated;
- worried about getting in trouble from administration;
- sorry; and/or
- uncaring.

How do you think Mrs. Lawrence was feeling at the end of the sequence?

Some expected responses:

- humiliated;
- angry;
- powerless;
- like a child; and
- trust was violated.

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What strategies can you suggest when negotiating the use of the call bell? Would these strategies work in your setting?

Possible strategies:

- attempt to understand why Mrs. Lawrence rings so often. People who ring persistently may be anxious or afraid of not getting help when they need it; and
- enable Mrs. Lawrence to develop trust by negotiating times when you will return and then follow through as agreed.

2. Scott McArthur (Video/DVD position 15:50)

In this sequence Scott, a man with cerebral palsy, is given his dinner tray but not assisted with eating the meal. The delay in his speech prevents him from alerting the nurses who check in on him. The nurse finally removes the tray and Scott ends up not eating. Scott portrays himself in this scene. He explains how he feels when this happens to him.

Discussion Questions

What kind of abuse is demonstrated in this scenario?

Some expected responses:

Emotional abuse and neglect:

- "I don't know if I will get to eat today."
- "I should just be grateful someone is helping me."

What factors contributed to the abuse happening?

Some expected responses:

- lack of knowledge of client's specific traits and conditions that influenced his response to the situation;
- failure to take time to understand the client's needs; and
- failure to communicate the client's needs with members of the nursing staff.

Do you think the nurses were aware that they had neglected Scott?

Expected response:

- No. Their interactions were friendly, cheerful, no evidence of intent to neglect or conflict.

Is intent a consideration in deciding whether behaviours are abusive?

The nurse's intent is not a factor in determining whether an act or behaviour is abusive. The basic premise of the provision of nursing care is to do good and to do no harm. That harm was unintended is not a defence if the nurse knew or ought to have known that the act or behaviour would cause harm.

What strategies would you implement to prevent this from happening?

Strategies include:

- effective communication among caregivers about the needs of clients;
- seek additional specialized knowledge required to provide safe, effective and ethical care to clients with special needs; and
- take time to listen to clients and determine their perception of needs.

3. Annie (Video/DVD position 16:45)

In this sequence Annie, an elderly woman who is confused, is approached by two nurses to prepare her for a bath. They enter the room and start undressing her as they explain what they are doing. Annie is startled and starts to resist their efforts. The situation escalates until Annie becomes combative and starts to cry. Follow-up sequences explore some alternatives to managing confused clients and strategies to prevent such an incident from happening again.

Discussion Questions

What factors may have influenced the behaviour of the nurses?

Some expected responses:

- focused on their own schedule;
- were not aware of the effect that their approach and actions had on the client;
- lack of knowledge of how to manage clients with dementia; and
- did not assess underlying meaning of behaviour.

What factors influenced Annie's behaviour?

Some expected responses:

- the nurses frightened Annie, and fear caused Annie to strike out;
- client may have had another negative interaction that day or was remembering one from a previous time; and
- client may be embarrassed to have the nurses bathe her.

Why would this be considered to be abuse?

Some expected responses:

- this interaction violates all the principles of the nurse-client relationship: trust, respect, professional intimacy, empathy and power;
- the client's needs/preferences were not treated as paramount; and
- the nurses were meeting their own needs — to get Annie bathed when it suited them.

How could you use the strategies recommended in the video to prevent abuse in your practice setting?

Some expected responses:

- redirect the client; and
- explore the underlying meaning of the client's behaviour.

What other strategies have you found helpful in dealing with similar situations?

Use this question to focus the group discussion on sharing ideas and strategies.

4. Evaluation Form. (See Supplement 2.)

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Recognizing Sexual Abuse

Purpose

To increase awareness of subtle forms of sexual abuse that may occur in nursing practice.

Learning Outcomes

- Understand how the actions of the nurses in the video violate the therapeutic relationship
- Be able to recognize sexual abuse
- Understand the impact of abuse on the client
- Be knowledgeable about reporting requirements related to sexual abuse

Learning Activities

1. Remarks of a sexual nature (Video/DVD position 20:40)

In this sequence, two female nurses are providing care for a post-operative client who had a TURP. As they reach the door of the room, they start giggling and making jokes and remarks that have a sexual connotation. The client hears the remarks.

Discussion Questions

What kind of abuse was this?

Some expected responses:

- sexual abuse – the remarks were of a sexual nature; and
- emotional abuse – the client experienced humiliation and shame.

How do you think the client was feeling after this exchange?

Some expected responses:

- embarrassed;
- humiliated;
- angry;
- ashamed; and
- afraid.

How might this incident affect the nurse-client relationship?

Some expected responses:

- betrayal of trust, intimacy, respect;
- client may not trust the nurses – could lead to increased anxiety; and
- may respond negatively to their care – may act out.

What would you do if the client reported to you that he had overheard nurses making inappropriate sexual remarks about him?

You should:

- listen to the client;

- explain that such behaviour is unacceptable and that you are required to report it;
- seek permission from the client to use his/her name in the report to the College; and
- make a written report to the College of Nurses of Ontario within 30 days.

Additional recommendations:

- discuss the incident with the nurses, if you are able to, so that they can be made aware of the impact of their behaviour in order to avoid such remarks in future;
- discuss the incident with your supervisor.

2. Sexual abuse case

A male nurse has been providing counselling to a female client who has presented with mental health issues. In one of the counselling sessions, the male nurse hugs the client, asks the client if she has a boyfriend and then asks her out to dinner. The client clearly looks uncomfortable and does not feel that her concerns are being taken seriously and pushes the nurse away. The nurse has crossed many boundaries in the therapeutic relationship, including inappropriate remarks, comments and touching.

Discussion Questions

What kind of abuse is this?

Some expected responses:

- sexual abuse: inappropriate touching, behaviour of a sexual nature; and
- emotional abuse: nurse was using the relationship to meet his own needs. Behaviour caused the client obvious distress.

What clues would tell you that the client is uncomfortable?

Some expected responses:

- pushing nurse away; and
- looks uncomfortable.

What boundaries of the therapeutic relationship did this nurse cross? Give examples.

Some expected responses:

- violated the principles of trust, respect, professional intimacy, empathy and power;
- did not respond to the clients' cues of discomfort and stop behaviour;
- did not demonstrate the understanding he ought to have regarding the boundaries of the therapeutic relationship;
- actions suggested a desire to initiate a romantic/sexual relationship; and
- unacceptable communication, touching.

What would you do if a client reported this situation to you?

- listen to the client;
- explain that such behaviour is unacceptable and that you will report it;

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- seek permission from the client to use her/his name in the report; and
- if the incident seemed possible/reasonable that it could have occurred make a report in writing to the College of Nurses of Ontario within 30 days.

Additional recommendations:

- Discuss the incident with your supervisor.

3. Evaluation Form. (See Supplement 2.)

Boundaries in the Nurse-Client Relationship

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Purpose

To understand how caring can cross the therapeutic boundary and recognize the clues indicating over-involvement.

Learning Outcomes

- Understand the concept and reason for boundaries in the nurse-client relationship
- Be knowledgeable about the nurse's responsibility to maintain boundaries
- Recognize the warning signs for crossing boundaries
- Understand strategies to maintain boundaries

Learning Activities

Prior to the session, ask participants to review the section on maintaining boundaries in *Therapeutic Nurse-Client Relationship, Revised 2006*. This section outlines the concept of boundaries and provides a number of strategies to assist nurses in setting boundaries.

1. Discuss the definition of "boundary" with participants.

(Write definition on flip chart or overhead.)

A boundary in the nurse-client relationship is the point at which the relationship changes from professional and therapeutic to non-professional and personal.

2. Read or hand out *one* of the following cases:

Case 1

A nurse is caring for a chronically ill adult. Whenever the client is hospitalized, the nurse insists on caring for her. The nurse comes in on her day off to visit with the client. When the client is home, the nurse volunteers to provide respite care for the family caregiver and to take the client on family outings. At the last care planning conference, the nurse became agitated when the client's care was being discussed with the family caregiver and health care team, stating no one but herself understood the client's needs.

Case 2

A nurse working in a community mental health program sits on a municipal board with a client who she counsels. The nurse often drives the client to the meeting because the client does not have a car. They sometimes go for coffee together after the meeting. Recently, they have planned shopping trips together on the weekend, and the nurse regularly phones the client. The nurse has also begun to confide in the client, telling the client about her problems at work and at home.

3. Discussion Questions

How would you describe the nurse's relationship with the client?

Some expected responses:

- non-therapeutic;

Notes

- evidence of over-involvement; and
- nurse's needs taking precedence over client's.

What behaviours of the nurse led you to these conclusions?

The following are warning signs that signal the need to clarify the nurse-client relationship. They're taken from the section on the warning signs of crossing a boundary in the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard.

- spending extra time with one client beyond therapeutic needs;
- changing client assignments to give care to one specific client;
- feeling other members of the team do not understand a specific client as well as you;
- disclosing personal problems to a specific client;
- dressing differently when seeing a specific client;
- thinking about the client frequently when away from work;
- being guarded or defensive when someone questions your interactions with the client;
- spending off-duty time with a client;
- ignoring policies of the agency when working with a specific client;
- keeping secrets with a client; and
- giving a client a home phone number when it is not required as part of the nursing role.

What factors do you think may have led to this kind of involvement by the nurse?

Some expected responses:

- caring for client fills a personal need/gap in the nurse's life;
- lack of understanding of personal boundaries and the risks of betraying the nurse-client relationship; and
- lack of knowledge of the potential negative impact of the relationship on the client.

How would you follow up with this nurse?

Some expected responses:

- speak to the nurse and identify the behaviours that you see as potentially problematic;
- refer the nurse to the employee assistance program; and
- recommend additional education regarding boundaries.

What could the nurse have done to prevent the situation from developing?

Some expected responses:

- be aware of her own needs and meet them outside of the client relationship;
- follow the care plan; and
- remember the context of care and that client/family needs to learn to cope on their own.

4. Evaluation Form. (See Supplement 2.)

Giving and Receiving Gifts

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Purpose

To increase understanding of when the giving and receiving of gifts is acceptable, and when self-disclosure is therapeutic.

Learning Outcomes

- Understand the issues associated with giving clients gifts, accepting gifts from clients and self-disclosure
- Be able to apply the concepts of boundaries in case studies and practice

Learning Activities

Prior to the session, ask the participants to review the section on maintaining boundaries and giving and accepting gifts in the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard.

1. Self-Disclosure

Discuss when it is appropriate to share personal information with clients. Read or hand out the following case study.

Case 1

Chris was caring for an elderly woman in a long-term care setting. Recently, Chris confided to her client that her car needed repairs, and she did not know how she was going to pay for them since her husband is out of work. The nurse also mentioned that she would have difficulty getting to work if the repairs were not made. The client became worried about Chris' situation. She asked her husband if they could lend Chris the money to help pay for the repairs.

Is this an appropriate use of self-disclosure? Why or why not?

Some expected responses:

- this self-disclosure was inappropriate;
- it met the needs of the nurse not the needs of the client, who is the focus of care;
- the client perceived the confiding as a request for assistance;
- it caused unnecessary worry for the client; and
- it is an abuse of the trust and intimacy in the relationship.

2. Accepting Gifts

Read or hand out the following case study.

Case 2

A nurse has been caring for an elderly client for several years. The client is a retired school teacher and has shared many memories with the nurse, including the story about a principal giving her a decorative box to commemorate her first year of teaching. One day, the client gives the nurse the box. The client explains that she wants the nurse to have the box because she feels the nurse is the only one who understands how much the box means to her and will look after it.

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3. Discussion Questions

What factors would you consider in deciding whether or not to accept the gift?

Some expected responses:

- Was the client mentally competent?
- Is the client expecting a different level of care?
- What is the value of the gift?

4. Giving Gifts

Read or hand out the following case study.

Case 3

One of Mary's clients is house-bound, with few external contacts. One day, while at a garage sale, Mary notices a little blue hippopotamus. Knowing that her client collects hippopotami, Mary buys it and presents it to the client. The client is very pleased and discusses the gift with the other nurses. The client states that, of all the nurses, she has always known that Mary was the one who really cares. One of the other nurses wonders if giving this small gift was appropriate.

What factors would you consider in deciding whether this gift giving is appropriate?

Some expected responses:

- It was not part of the plan of care and did not help the client meet needs for external contact and activities;
- Mary could have told the client it was a gift from the team to make the giving more appropriate;
- The gift could change the relationship between the client and Mary, as well as the client's relationship with the other nurses; and
- Mary needs to check the warning signs related to boundary issues.

5. Evaluation Form. (See Supplement 2.)

Acting to Stop Abuse

Purpose

Research has shown that nurses are very effective in acting to stop abuse. This module illustrates the importance of nurses intervening to stop abuse and suggests ways in which they can intervene.

Learning Outcomes

- Act effectively to stop or prevent abuse
- Understand the effectiveness of acting to stop abuse

Introduction for Facilitator

CNO's research on abuse prevention has found that nurses are both willing and successful in stopping abuse. Acting to stop abuse when it occurs is the professional responsibility of all nurses.

Intervening to prevent or stop abuse can take a number of forms. One very important type of intervention involves watching for the warning signs of abuse and intervening to protect clients from harm. This may involve:

- helping a colleague cope with a stressful situation;
- supporting a colleague in dealing with a client who displays difficult behaviours;
- approaching a colleague who has been aggressive with a client to make the colleague aware of her/his behaviour; and
- being available to colleagues to talk through problems and help develop strategies.

Other types of intervention include understanding what abuse is and helping to stop abusive situations. When intervening in an abusive incident, nurses can take the following steps:

- respond assertively;
- maintain eye contact;
- calmly tell the individual you do not approve of her/his abusive behaviour;
- focus on the individual's actions, not the individual personally;
- direct the individual's attention away from the victim;
- seek first-aid if necessary; and
- give an outlet for debriefing.

Reporting Abuse

In all cases of client abuse, nurses need to follow up on the incident with a report. When the abuse is verbal or physical, the obligation is to report it to the unit manager or employer. Depending on the severity, and whether the abuser is a nurse, the nurse may also want to inform the College of Nurses of Ontario. If the abuse is of a sexual nature, a nurse's responsibilities are defined by legislation. Participants need to be aware of these expectations.

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Mandatory Reporting Requirements: The *Regulated Health Professions Act* (RHPA) requires any health care professional who has **reasonable grounds** to believe that a client has been sexually abused by another health professional to report this to the regulatory college of the alleged abuser. Sexual abuse is defined in the RHPA, and includes sexual intercourse, touching of a sexual nature and behaviour or remarks of a sexual nature toward a client. The requirement to report sexual abuse by a regulated health professional to their respective College applies to information obtained in the course of practising the profession.

Reasonable grounds for making a report include:

- information received from a normally reliable source, such as another nurse; or
- reports from a client about a specific incident that occurred to him/her unless it was known the allegation could not be true (e.g., the person was not on duty on the day the abuse allegedly occurred).

Nurses are not required to investigate or make inquiries to confirm that an allegation is true before reporting it. Rumours or gossip, by themselves, would not constitute reasonable grounds.

If you have questions about filing a report about a nurse, call the College at 416 928-0900, or toll-free in Ontario at 1 800 387-5526.

Learning Activities

Using real instances of client abuse will be difficult for discussion. Accordingly, there are several situations on the video/DVD that illustrate abuse. The most appropriate for this discussion are:

Mrs. Lawrence (Video/DVD position 13:30): An elderly client who is portrayed as "difficult," constantly uses the call bell. On this occasion, the nurse was delayed by an emergency in responding to the bell. When the nurse answers the bell, the client is very indignant. She has wet her bed. The nurse scolds the client and then leaves her to sit in the wet sheets until she has time to change them.

Annie (Video/DVD position 16:45): An elderly woman, who is confused, is approached by two nurses to prepare for a bath. They enter the room and start undressing her as they explain what they are doing. Annie is startled and starts to resist their efforts. The situation escalates until Annie becomes combative and starts to cry.

Male client post-operative TURP (Video/DVD position 20:40): Two female nurses are providing care for a post-operative client who has had a TURP procedure. As they reach the door of the room, they start giggling and making sexual jokes and remarks. The client overhears these remarks.

1. Play one scenario from the Video/DVD and ask the following discussion questions.

If a nurse walked into this set of events, what could she/he do to defuse the situation? (Write suggestions on flip chart or overhead.)

Annie

Some expected responses:

- Tell the other nurse(s) that we will give Annie a break for a moment. Saying "This is not working right now. Leave her with me";
- Reassure Annie that she is not going to be harmed;
- When talking to Annie, bend down to her eye level;
- Give Annie an opportunity to respond;
- Follow up with your colleague, explaining that the behaviour is not appropriate; and
- Document the situation for yourself, and include the client's name, the date and the nature of the incident.

Mrs. Lawrence

Some expected responses:

If early in the situation

- Take over the care of Mrs. Lawrence when you notice that your colleague has become agitated.
- Provide an excuse to get your colleague away from the client, such as asking her/him to speak with you in the corridor.

If the nurse has verbally abused the client

- Ask your colleague to leave, and say that you will discuss the situation later.
- Offer Mrs. Lawrence an apology. Explain that the unit was just dealing with a crisis and offer an apology for not checking in on her first.
- Get fresh sheets for Mrs. Lawrence and ensure her needs are met.
- Immediately follow up with your colleague and discuss the situation. Explain that her behaviour was inappropriate.
- Document the situation for yourself; include the client's name, the date and the nature of the incident.

Post-Operative client who has had a TURP procedure

Some expected responses:

- Tell the nurses that their comments were very inappropriate.
- Call them to the nursing station or other area away from the client's doorway.
- Inform your colleagues that the client may have overheard the remarks.
- Document the situation for yourself, including the client's name, the date and the nature of the incident.

Should a nurse report these incidents? If so, to whom?

- Yes. In each of these situations, the intervening nurse should inform the team leader or manager about the incident. Ideally, the nurse involved in the incident will report it to the team leader, or both the intervening nurse and the nurse involved in the incident could report the incident together to lend support to each other.
- If the nurse involved in the incident refuses to report herself, the

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intervening nurse should inform the colleague that she/he will be reporting the behaviour. Then inform the team leader. While it is difficult to report a colleague, the nurse's responsibility is always to the client first.

- In the case of the post-operative client, this may be sexual abuse. Sexual abuse includes inappropriate remarks of a sexual nature made toward the client. Sexual abuse must be reported to the regulatory college of the alleged abuser. If reported to administration, the intervening nurse should confirm that the information was passed onto the appropriate college. If the nurse is unsure, she/he must call the College of Nurses of Ontario and report the incident. The nurse should document the efforts to report the event to the manager, employer and/or the College.

2. Evaluation Form. (See Supplement 2.)

Abuse of Nurses

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Purpose

Preventing the abuse of nurses is an important element in eliminating all types of abuse from the practice setting. This module addresses the prevention and management of the abuse of nurses and provides some basic techniques.

Learning Outcomes

- Define nurse abuse
- Understand the expectations of nurses for the prevention of nurse abuse
- How to react appropriately to aggressive behaviour by clients and other abusers
- Responsibility to advocate for effective abuse prevention measures in the practice setting

Introduction for Facilitators

Review CNO's *Nurse Abuse* practice guideline. It explains the expectations for nurses and other health care partners when confronted with aggressive or abusive behaviour. It describes the risk factors for abuse and strategies for managing abusive behaviour. As well, it provides scenarios that illustrate the concepts.

The key message is to manage an abusive situation in a safe, effective manner by:

- assessing the potential cause(s) of the abusive behaviour as well as the danger to clients and themselves;
- creating a care plan to address the cause(s) and the behaviour;
- involving the client and family in the creation of the care plan;
- considering the impact of a client's health state on his/her behaviour; and
- seeking resources and expert assistance to deal with the situation in a timely manner.

During your session, you will likely be asked about self-defence. Nurses can and should protect themselves in situations that threaten their personal safety. Nurses should always be alert to potentially abusive situations and make a plan to protect their personal safety, such as planning a route of escape.

When there is a threat of imminent physical harm, nurses may use only reasonable force to protect a client, a colleague or themselves. Reasonable force is relative to the situation, and the force used should be the minimum required to protect yourself, a client or a colleague. For example, if a client grabs a nurse she/he may be able to brush the client's arm away and stop the abuse. This would be reasonable. Similarly, the force required to defend yourself from a frail elderly person is likely less than that required to respond to a young adult.

While nurses should take action to address and manage abusive behaviour, they must always respect their clients, maintain client safety and never intentionally inflict harm.

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Learning Activities

Option A

1. Discuss the College's *Nurse Abuse* practice guideline.

- Review expectations for nurses. Discuss how a client's intent and mental impairment affect the way nurses respond and manage aggressive behaviour.

2. Select a case from the guideline, or develop your own, and distribute to nurses. *(Write responses on flip chart or overhead.)*

- Choose a scenario that is relevant to the participants' practice setting. Ask the participants to review the case and offer suggestions on how best to deal with the incident.

3. Ask participants to identify risk factors in their practice setting for the abuse of nurses. *(Write responses on flip chart or overhead.)*

- Provide additional examples from the *Nurse Abuse* practice guideline, in the section on potential risk factors for the abuse of nurses.

4. Ask participants to describe how they currently manage these risk factors. *(Write responses on flip chart or overhead.)*

- Encourage participants to come up with other possible strategies for managing abusive situations.

5. Ask participants to come up with different approaches that could be used in their setting. *(Write responses on flip chart or overhead.)*

- Select appropriate items from the *Nurse Abuse* practice guideline, in the section on strategies for dealing with abuse.

6. Evaluation Form. (See Supplement 2.)

Option B

1. Role Play

Role play a situation in which a client, a client's family member or another member of the health care team is verbally abusing a nurse.

If possible, use an example of an actual incident that occurred in your practice setting. Have one nurse play the abuser and another an intervener trying to calm the situation.

Sample role-play scenario

Joanne, an experienced nurse, is walking down the hall when she hears Tom Smith, a 20-year-old client with paraplegia, swearing loudly. He shouts, "Get away from me you useless piece of garbage!" Joanne overhears her colleague, a young nurse named Suzanne, respond angrily: "I don't have to take that kind of language. If you are not more polite you will have to do your own dressing. I'm leaving now and may not be back later." Joanne meets Suzanne coming out of Tom's room. Suzanne says she is humiliated by Tom's outbursts. Tom is always angry with her except when he is making personal comments about her appearance. She states that initially she and Tom got along fine and they

laughed and joked a lot. Recently, though, Tom has turned nasty and doesn't seem to realize when to draw the line. Suzanne says that she is unable to cope with Tom any longer.

2. Discussion Questions

How did Suzanne handle the situation?

Some expected responses:

- she reacted personally instead of thinking about the underlying meaning behind the behaviour.

Why might Tom have been reacting the way he did?

Some expected responses:

- he may be having difficulty accepting his condition;
- he may be attracted to Suzanne and angry at her lack of response; and
- he may think Suzanne was flirting with him when she laughed and joked with him.

What could Suzanne have done differently?

Some expected responses:

- Suzanne needed to set the boundaries a lot sooner in the relationship and be aware of the needs of the client.

What can Joanne do?

Some expected responses:

- Take over the immediate care of Tom for the short term, giving Suzanne time to develop a plan for dealing with the situation.
- Discuss with Tom the reasons for his behaviour.
- Discuss with Suzanne possible solutions to the situation with Tom and strategies for avoiding similar situations in the future.
- Develop a care plan or approach for Tom.
- Support both Suzanne and Tom.

3. Evaluation Form. (See Supplement 2.)

Notes

Supplements

Self-Reflection Questionnaire

Part 1

Please take a few minutes to answer the questions below, basing your answers on your personal values and practice experiences.

I think it is important to show clients and their families that I am in charge. ❑ Yes ❑ No

Sometimes there is no need for a care plan. ❑ Yes ❑ No

It is okay to spend off-duty time with a client. ❑ Yes ❑ No

At times it may be necessary to keep something a client has told me from the other members of the health care team. ❑ Yes ❑ No

When my colleagues behave inappropriately toward clients, I do not know how to deal with it. ❑ Yes ❑ No

When a client hurts me, I strike back or find I am rough with him or her. ❑ Yes ❑ No

Other members of the health care team do not understand some clients as well as I do. ❑ Yes ❑ No

It is important to make clients understand that the nurse really knows what is best for them. ❑ Yes ❑ No

A nurse may sometimes give a gift to a client. ❑ Yes ❑ No

Some of my clients are my friends. ❑ Yes ❑ No

Part 2

Completing these statements will help you explore some of the values that you bring to interacting with clients.

1. Abuse of clients is …

2. My role as a nurse is to …

3. When I feel frustrated caring for a client who exhibits difficult behaviour, I …

4. When I am stressed at work I usually …

5. In my interactions with clients, I like myself most when I …

6. If I heard that a health professional was sexually abusing a client I would …

7. If I saw a colleague being rude to a client I would …

8. One way I can avoid a situation which might be abusive to a client is …

Evaluation Form

To assist CNO in evaluating the effectiveness of the *One is One Too Many* program, please complete a photocopy of the following form and return it to:

College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1
Attention: Manager, Practice or Policy

Name (optional):_____ Telephone (optional):_____

Address (optional): _____

Date(s) of education session(s): _____

Setting in which you work or where you attended the session. Please choose one of the following:

- ❑ Hospital
- ❑ Long-term care facility/organization
- ❑ Community care provider/employer in the community
- ❑ Other, please specify_____

1. What part of the *One is One Too Many* program did you use? Check all that apply.
   - ❑ Facilitator's Guide
   - ❑ Video/DVD
   - ❑ Workbook
2. What do you use *One is One Too Many* for? Check all that apply.
   - ❑ Education sessions
   - ❑ Reflective Practice
   - ❑ Other, please specify _____
3. What part of the program do you find most useful?
   - ❑ Facilitator's Guide
   - ❑ Video/DVD
   - ❑ Workbook
4. Why was the part identified in question 3 useful?_____

   _____

   _____
5. What changes would you like to see made to the *One is One Too Many* program? _____

   _____

   _____
6. Overall, what do you think of this program? _____

   _____

   _____

Summary of Video/DVD: *One is One Too Many*

The following table explains the key scenes in the video and how they could be used for discussion. You may discover more discussion points as you become familiar with the video/DVD.

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
00:00 00:20	***Opening Montage*** Short clips from the scenarios that display abuse.	The opening montage is meant to reflect different areas of abuse in many practice settings. A stressful environment is one factor that may increase the risk of client abuse.	
00:20 00:45	***Introduction*** Narrator Sandra Keating, RN, CNO President (2005-2006) and practising nurse, introduces the video.		
00:45 05:45	***Round Table Discussion*** (Participants in order of appearance: Adrienne Cunnane, RN Carol Nafziger, RN Marina Gibson, RN Kim Anderson, RPN Ross Smith, RN) The round table participants talk about their experiences and pressures in the work environment, and make comments such as "…There's so much pressure in being a nurse, in everything that we do, whether it's community based, whether it's acute care, whether it's long term care." "…you want to give good care. And that is challenging when you have a heavy case load."	The responses from the round table participants were not scripted. The nurses are talking about their own experiences. Refer to *Factors which may Increase the Risk of Client Abuse* (Appendix 2) to determine how the situations discussed by the nurses could increase the risk of abuse. Sandra describes how nurses may feel powerless. Nurses often feel powerless in their workplaces. They have difficulty knowing what they can control and how they can support each other. Many strategies, like offering to help a colleague who looks frazzled, are easy to implement and cost nothing.	▪ How are the feelings of the nurses the same/different from your own? ▪ How do the situations they describe affect risks for abuse of clients? ▪ How does stress in the workplace contribute to client abuse? ▪ What kind of supports do you have to cope with stress? ▪ How does stress affect your colleagues and their response to clients? ▪ Compare how this definition fits with nurses' perception of what abuse is.

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
	Sandra, the video narrator, describes how often nurses feel that they are "…a cog in a great giant wheel of healthcare delivery in the province of Ontario…" and they feel sometimes almost powerless. Adrian, states that, "Everytime time you walk in to care for a resident or a client, you have to leave the stress outside the door." Sandra describes the definition of abuse.* Abuse can be physical, or non physical in nature. Adrian describes the types of abuse such as financial, sexual,** physical, verbal but often one forgets that neglect is also considered abuse. Carol describes how often abuse is subtle and that people may not see it as abuse and may not recognize it as abuse.	Abuse can be physical ,emotional, verbal, and sexual abuse,** neglect and financial Abuse is the misuse of power and/ or the betrayal of trust, respect, or intimacy between the nurse and the client, which the nurse knew or ought to have known can cause or be reasonably expected to cause physical or emotional harm to the client. Carol describes the grey areas*** of abuse.	▪ What is meant by "grey areas" of abuse? ▪ What can nurses do to prevent subtle forms of abuse?

* This definition encompasses physical, emotional, verbal, and sexual abuse. Neglect and financial abuse also fall under this definition.

** Sexual abuse of a client by a member of a regulated health profession is defined specifically in the *Regulated Health Professions Act* (RHPA) as follows:

- sexual intercourse or other forms of physical sexual relations between the member and the patient;
- touching, of a sexual nature, of the patient by the member; or
- behaviour or remarks of a sexual nature by the member towards the patient.

*** Grey areas of abuse are acts or behaviours that may be considered abusive in some situations. Often these result from lack of sensitivity to the client's needs, cultural beliefs and values, or from failure to communicate with the client. Examples include calling an elderly person by his or her first name. This could be considered disrespectful by the client, depending on personal values.

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
5:50 9:20	***Scenario: Neglect and Emotional Abuse—Scott*** In this sequence Scott, a man with cerebral palsy, is given his dinner tray but not assisted with eating. The delay in his speech prevents him from alerting nurses who check in on him. The nurse finally removes the tray and Scott ends up not eating. Scott portrays himself in this scene. He explains how he feels when this happens to him or when nurses talk as if he can't hear them. ***Discussion:*** Ross describes that abusive situations which he has witnessed involve clients who are most vulnerable. He explains that "client focus is as simple as putting yourself in that person's place…"	This scene often evokes an emotional response from viewers. Although the nurses were pleasant and friendly, they failed to take enough time to fully understand Scott's needs. The nurses did not intend to neglect Scott. However, intention is not a factor in determining whether an action is abusive. In this case, the nurses ought to have known that Scott would need help with his tray from observation of his spasticity. His slow speech should have alerted them that they would need to take extra time to hear a response to questions. Nurses are expected to obtain the knowledge, skill, and judgment to care for their clients safely, effectively, and ethically. Therefore, the nurses would have been expected to learn about the care of a client with cerebral palsy. Good communication among nurses through an individualized care plan might have assisted nurses to prevent this situation.	

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
09:25 13:30	***Scenario: Financial Abuse—Mr. Lee*** In this sequence, a community health nurse is visiting a client in the home. While talking, the nurse tells the client about his financial problems. The client responds with concern, and offers the nurse a gift of money. This scenario addresses the grey areas of crossing the boundaries such as self-disclosure and accepting gifts from clients. ***Discussion:*** Nurses discuss how to recognize and manage boundary issues.	There are number of warning signs you can look for to indicate that you or a colleague may have crossed the boundaries. Warning signs include: ▪ wanting to look attractive for a particular client ▪ keeping secrets about the client from the health care team ▪ exchanging phone numbers or personal information with the client ▪ favoring one client over other clients ▪ changing assignments to care for one particular client.	See Learning Module 7.

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
13:30 16:40	***Scenario: Emotional and Verbal Abuse and Neglect — Mrs. Lawrence*** This scenario features an elderly woman who is portrayed as "difficult". Mrs. Lawrence constantly uses the call bell. On this occasion the nurse was delayed in responding to the bell, and the client is very indignant. She has wet her bed. The nurse scolds the client and then leaves her to sit in the wet sheets until she has time to change them. ***Discussion:*** The round table group discusses why this is abuse and identifies what the nurse should have done.	Many nurses have difficulty seeing how the nurse in the scene abused power. They see the client as having the power because she says she will "call administration." In reality, it is the nurse who holds the power. Mrs. Lawrence's lack of power can be seen in the fact that she: ▪ cannot look after her bodily functions without the nurse; ▪ is verbally aggressive because she feels vulnerable; and, ▪ is in bed with the bed rails up and has no control over her mobility. She relies on the nurse for everything. Persistent use of the call bell is usually a symptom that the client is anxious or fearful that her/his needs will not be met. Failure to respond to the call bell perpetuates the anxiety and fear, possibly promoting a cycle of abuse. Seeking to understand what is underlying the client's frequent need to use the call bell and negotiating with the client how to meet those needs can help break the cycle.	See Learning Module 4. Other points to consider and discuss are: ▪ what communication styles do the nurse and client use? ▪ identify barriers to communication? ▪ identify strategies for handling "demanding" client? ▪ what is the nature of this nurse-client relationship (issues of class, role perception)?

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
16:45 20:40	***Scenario: Physical and Emotional abuse—Annie*** In this scenario, Annie, a confused elderly woman, is approached by two nurses who want to prepare her for a bath. As the nurses undress Annie, she become startled and resists their efforts. The situation escalates until Annie becomes combative and starts to cry. ***Discussion:*** The round table group explores some alternatives to managing confused clients and strategies to prevent a situation such as this. The group discusses the importance of communicating with clients, gaining trust and listening to their concerns. A short sequence demonstrates how a confused client could be redirected.	Forcefully undressing a client or forcing the client to have a bath is physical abuse. Clients have the right to consent to treatment of any kind. Even persons who are confused or mentally incompetent may be able to make some choices. (*The Consent to Treatment Act, 1992*.) The nurse's approach can trigger aggressive or resistant behaviour from a client. As discussed in the video, taking a little extra time in the beginning and analyzing behaviours of both the nurse and the client can both save time and prevent abuse of both the client and the nurse. Routines often dictate the client's care. When the client's individual needs are not considered, the potential for abuse increases.	See Learning Module 4. Other questions for discussion: ▪ what alternative approaches might the nurses use?

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
20:40 21:55	***Scenario: Sexual Abuse—Male Client*** In this sequence, two female nurses providing care for a post-operative TURP client, laugh and make sexual remarks and jokes outside the client's room door. ***Discussion:*** Sandra Keating provides information on the definition of sexual abuse and the mandatory reporting requirements for regulated health professionals. All health professionals are required to report any incident of sexual abuse directly to the appropriate regulatory college. Furthermore, nurses are expected to report any incident of unsafe practice or unethical behaviour on the part of a health care provider to their supervisor or employer, or directly to the appropriate College.	Remarks of a sexual nature directed at a client are considered sexual abuse. In this scene, the male client overhears remarks made by the nurses outside the door. Some nurses may view the scenario as being more emotional abuse than sexual abuse. It is difficult to completely separate types of abuse. In any form of abuse there is an emotional component: clients are left feeling vulnerable, powerless, and demeaned. The scenario also illustrates the power dynamic in the nurse-client relationship that is further enhanced by the male-female relationship. Sharing a joke with a client that has sexual overtones could be considered a remark of a sexual nature. Cultural beliefs may also define remarks as sexual, even if they are not commonly considered so. Nurses are accountable for acquiring the knowledge, skill, and judgment required to determine appropriate behaviours with respect to their own and client's personal and cultural values, beliefs, and traits which influence reactions/responses to different caregivers and situations. See Learning Module 5	See Learning Module 5.

Cue on Video/DVD	Scene Description	Explanations/ Interpretations	Discussion Points/ Questions
21:55 24:22	***Preventing and Responding to Abuse*** Sandra discusses how to respond when a nurse witnesses or hears about abuse that is non-sexual in nature. She notes that awareness of abuse can lead to prevention. Information on contacting the College for more information.		
24:23 25:20	***Closing Remarks and Montage*** Sandra: "One is one too many. We don't want to see anybody hurt out there, and that is what this video is all about. It's about helping you understand that you are not alone in your practice. Hopefully it has given you some strategies to manage boundaries on your own, to recognize and be aware of the subtleties of abuse and to help prevent it."		

Introduction

By agreeing to be a facilitator and leading education sessions for nurses, you are taking an important and active role in preventing the abuse of clients. This program is designed to be easy to use and flexible enough to be adapted to almost any practice setting. All of the information you need for a successful session is included in this binder.

One is One Too Many is CNO's main educational program on abuse prevention. It contains a broad range of background materials and different learning tools to allow you to address all types of audiences and a wide variety of topics. The materials in this Facilitator's Guide include:

- the College's *Therapeutic Nurse-Client Relationship, Revised 2006,* practice standard;
- the *One is One Too Many* video, DVD and learning modules;
- the *Nurses' Workbook on Preventing Abuse*;
- CNO research on the abuse of clients;
- a bibliography on abuse prevention and adult education; and
- the College's *Nurse Abuse* practice guideline.

Before planning your session, we recommend that you take a moment and acquaint yourself with the contents of this binder.

Program Goals

The goals of the *One is One Too Many* program are to help nurses:

1. recognize abuse and identify factors or situations that increase the risk of client abuse;
2. explore values, beliefs and attitudes about the abuse of clients by nurses;
3. identify boundaries in the nurse-client relationship and warning signs for crossing these boundaries;
4. identify environmental factors relevant to specific practice settings that increase the risk of client abuse;
5. develop personal strategies for preventing abuse;
6. develop setting-specific strategies for preventing abuse;
7. understand CNO's expectations regarding the prevention of client abuse; and
8. know the methods for managing alleged abusers and victims, and about nurses' responsibilities for reporting sexual abuse.

Who Should Use this Program?

The education program can be adapted for use in many agencies or practice settings. While some generic strategies for preventing abuse are described in this guide, for the guide to be relevant to the person and the environment in which care is provided, specific strategies need to be determined by the people involved.

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Learning Methods

This program has been designed to be learner-centred, emphasizing experiential learning and critical reflection. Facilitators may select or adapt the learning modules and program options to meet the particular learning needs of the nurses at their facility.

The information will assist novice and expert facilitators to use the resources in this education program. If you are an experienced facilitator, you may prefer to use other methods to deliver material and encourage participation. The objectives listed in each learning module are intended as guidance and may be modified to suit your personal style and audience.

Program Evaluation

We welcome and encourage feedback from facilitators and participants about:

- the quantity and quality of materials included in this package;
- the usefulness of the learning guides;
- which learning modules were used most;
- how the learning modules or the program were modified to fit your setting;
- the effectiveness of the modules in achieving learning outcomes;
- what additional resource material would help you;
- what further learning activities you would recommend; and
- how completing the program affected the nurses, nursing practice and your organization.

We ask that you complete the Evaluation Form. (Supplement 2.)

We are also interested in hearing how the program has affected change in nurses' attitudes, beliefs and behaviours concerning the abuse of clients, nursing practice in your workplace, and what strategies you have implemented to prevent the abuse of clients. Please return evaluations, reports, feedback and comments to:

Practice and Policy Department
College of Nurses of Ontario
101 Davenport Rd.
Toronto, ON M5R 3P1

How To Use this Resource

1. Who Should Facilitate?

Volunteer facilitators from within your organization or facility are needed to effectively implement this program. It is suggested that a team of facilitators work together to enable broader access to the material by nurses, and to allow facilitators to support each other in dealing with such a difficult topic.

The contents of the abuse prevention program may call into question existing assumptions about the values and practices that guide nursing care and, as such, may produce emotional or negative reactions. It is important that the facilitators have the skills to manage the potential reactions of participants and the support to manage their own responses.

Some of the qualities of successful facilitators include:

- experience facilitating small-group learning;
- respect and trust within the organization;
- excellent problem-solving skills;
- excellent communication skills;
- prepared to commit to implementing the program;
- knowledge of the subject of abuse; and
- support from the administration to implement the program.

Note: The nurses we consulted indicated that group discussion may be restrained if a manager or supervisor facilitates. Therefore, it is recommended that the facilitator be a non-management colleague.

2. Develop a Program

The program works best when a series of learning activities relating to abuse prevention is planned and implemented over a period of time. It is strengthened by a supportive work environment, continuing education and ongoing positive reinforcement. Commitment to, and support of, the program by nursing administrators and managers is vital to its success.

3. Use the Resources

The video/DVD, facilitator's guide and *Nurses' Workbook on Preventing Abuse* are used together to stimulate discussion about the issues. The other sections of this binder provide guidance and resource material that are helpful in meeting the program objectives.

This facilitator's guide assists individuals leading small-group discussions and offers several options for organizing education sessions using the learning modules provided. The case studies in this guide can be modified to fit the work setting.

The prevention of abuse is a complex subject that requires an understanding of current values and beliefs, changing attitudes and creative problem-solving.

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Small-group discussion is the preferred primary teaching method. The College recognizes that some nurses work in isolation or may not be able to attend small group discussions. The *Nurses' Workbook on Preventing Abuse* has been developed for use by these nurses.

Supplement 1 (Self-Reflection Questionnaire) is designed to help participants consider their knowledge and attitudes about abuse. Completing this questionnaire before and after participating in the program will help participants evaluate the knowledge that they've gained.

4. Where to Get Help

CNO staff is available to provide assistance with the *One is One Too Many* program. If you need help or have questions, please contact the College of Nurses of Ontario.

Tel.: 416 928-0900 or toll-free in Ontario at 1 800 387-5526

Fax: 416 928-6507

Website: www.cno.org

Suggestions for Facilitators

It is important to assess, plan, organize, implement and evaluate the education sessions. The following steps can help you successfully facilitate the education sessions.

1. Assess your abilities to facilitate the education sessions.
2. Familiarize yourself with the content of the video and learning package.
3. Familiarize yourself with the policies and procedures related to abuse prevention at your organization.
4. Identify the participants' learning needs and preferences.
5. Choose a facilitation strategy that fits your knowledge, skills and experience, the participants' needs and the practice setting.
6. Develop a list of local resources, including contact names and phone numbers, to assist nurses who experience an emotional response to the issue of abuse. Resources to consider include:
   - Employee Assistance Program (EAP);
   - sexual assault centre;
   - crisis line;
   - reliable counsellors in the area; and
   - victim support groups.
7. Organize the education session (see the Workshop Checklist in Facilitator's Resources).
8. Walk through the program in advance of the session to determine timing.
9. Implement the program using a learner-centred approach.
10. Evaluate both the process and the outcomes of the sessions/program.
11. Encourage the participants to continue to learn abuse-prevention strategies and invite their feedback and recommendations.

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Facilitation Strategies

This section provides information on facilitating small-group sessions.

It contains facilitation strategies: how to set the tone and pace, develop rapport, enhance your ability to think on your feet and engage participants in the learning activity. You will also learn how to deal with difficulties and methods to handle emotional or negative reactions.

Experienced facilitators may wish to skip this section.

Facilitation Skills

There are many books, journal articles and professional associations devoted to adult learning. For more information on the subject, see the bibliography in the Facilitator's Resources section.

Here are a few tips to help you get started.

A. Set the Tone

1. Emotional Environment

- Create a comfortable and friendly environment where participants can feel safe to discuss sensitive issues.
- Use warm-up activities to reduce anxiety and encourage participants to get acquainted. One activity is to ask participants to describe in two words how they are feeling. For example, "scared and apprehensive" or "angry and frustrated" gives the facilitator a sense of the mood of the group at the moment. Another effective exercise is to ask participants to find a partner, interview each other or find three things that they have in common. Then ask the participants to introduce their partner to the group.
- Encourage participation and risk-taking through positive reinforcement.
- Reassure participants that their opinions will be respected, and honour the promise of confidentiality, with the exception of the disclosure of sexual abuse of a client.
- Maintain a non-judgmental attitude and avoid telling people what is "right" and "wrong," unless there are laws, standards or policies that must be followed. It may be appropriate to add your own opinion after other group members have shared their ideas.
- Be a member of the group rather than an observer. Share your experiences and work with participants to meet objectives and solve problems.
- Use humour cautiously. If you doubt the appropriateness of a joke, don't use it.

2. Physical Environment

- Arrange the room to encourage interaction. Set out chairs in a circle or around a small round table. Avoid classroom-style seating, if possible.
- Ensure that the room will comfortably accommodate all of the participants.
- Avoid the use of a lectern or other barrier between you and the participants. Keep the Facilitator's Guide and other materials on your lap, the floor or on a table beside you. Pick them up as you need them.

- Use flip charts and other interactive tools to note the participants' thoughts and ideas.
- Arrange the room so that everyone can see the audio-visual aids, the facilitator and each other.
- If possible, provide ambient background music when participants are arriving and during breaks.

B. Set the Pace

1. Keep the Session Moving

- When the group discussion moves off topic or bogs down, use the following steps to get it moving again.

Redirection: Acknowledge the importance of the issue that has been raised, and then refocus the group on the issue that is under examination.

Example: During a discussion about a client who was verbally abused by a nurse, the group veers off topic to discuss the number of times nurses have been abused. The facilitator interrupts the discussion and says, "Nurse abuse is clearly a concern to the members of the group. I suggest we record this on the flip chart as an issue that needs follow-up at a future meeting."

Confronting issues: The facilitator can challenge the group's behaviour to help participants reflect on their behaviour and learn from it.

Example: In the above scenario, the facilitator may say, "We seem to be unable to talk about the issue of verbal abuse of clients. Every time we try to get back to the discussion, the group raises the concern of nurse abuse. We seem unwilling to remain on topic. I think this is something we should stop and deal with."

If an important subject rises before or during the session, you may need to alter the agenda. You will need group consensus to do this.

Example: If a critical incident, such as an unexpected death, happens just prior to the education session, participants may be unable or unwilling to focus on the discussion topic. Reflect your observations to the group and suggest that the planned session be rescheduled. Example: "I can see that many of you are upset about the incident with Mr. Jones. I am wondering if we will be able to carry on with the abuse prevention session that we have planned for today. I am willing to reschedule this session to another time, and we can use this time to talk more about the incident. Or we can take 10 minutes now to talk about the incident, then carry on with the planned session and stay a little bit longer. What does the group suggest we do?"

2. Provide Stress Breaks

- Provide a five-minute break every 45 minutes. The learning span of most adults is no longer than 45 minutes. Getting the group to stand up and stretch or take a quick comfort break will help them keep pace.

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- Provide 15-minute breaks at least every two hours for longer education sessions. You may want to do an activity at this time to relieve stress. For example, have participants play a short game, participate in a team-building activity or tell a funny story.

3. Vary Learning Strategies

- Mixing passive activities (watching the video, time for reflection) with active activities (discussion, role play) facilitates learning.
- Large-group discussion can alternate with small-group (pairs or groups of three) discussion.

C. Establish Rapport

Rapport is the relationship that occurs within the group. It consists of feelings of mutual regard, respect and acceptance.

1. Know your Group

Before the session

- Select a group of participants who you feel is appropriate for the topic. Nurses who participated in CNO's consultation process said that they would be most likely to talk about client abuse issues with nurses whom they know well or whom they work with. This selection would also enable the nurses to support each other on an on-going basis. Determining the appropriate group can be accomplished through a learning needs assessment.
- Learn as much as you can about the group before the session. What is the preferred learning style of participants? Are they willing to participate in role playing or do pre-session reading? It may be helpful to meet informally with some of the participants to identify any potential issues that may influence the group's response to the education session (e.g., lay-offs, client complaints, intra-group problems).

During the session

- Ensure that participants are introduced to each other.
- At the beginning, let the group know what is planned, what the goals are, how the session will proceed and that, aside from the disclosure of sexual abuse, confidentiality will be respected. It is helpful to present the meeting plan as a written agenda on a flip chart or as a handout.
- Identify assumptions you have made about the group's knowledge of abuse prevention and their reasons for attending the session.
- Share feedback from the learning needs assessment, if you conducted one.
- Establish the "ground rules" with the group such as, "Everyone's contributions will be respected," or "We want everyone to have the opportunity to share their ideas." The caution about disclosure of sexual abuse of clients should be discussed at the beginning of the session.
- Model the behaviour that you expect from the group. Show respect for the participants' ideas, feelings and opinions.
- Be aware of the actions of participants. Some participants may go to the washroom or refill their coffee cup when a particularly difficult subject is

raised. If certain people continually move around or are out of the room when difficult issues are being discussed, they may be practising avoidance. There could be personal issues that they are uncomfortable discussing in a group. Respect that and provide time at the end of a session to identify some resources to help them.

- Provide support for participants who express dissenting viewpoints.
- Demonstrate interest in hearing and learning from participants.

After the session

- Thank the participants. You may want to create and hand out certificates of participation, or send individual or group memos acknowledging participation. If a series of sessions is being offered, you may want to develop a card that has lists all of the sessions; it can then be stamped or initialled at the completion of each session. If possible, have completed cards entered for a door prize at the end of the series.
- Follow up on any issues or questions that were raised at the session and get back to the individual or group with the response in a timely manner.
- Let participants know how they can contact you for further information or if questions arise after the session.

D. Engage the Participants

- Recognize each participant's knowledge and experiences. Provide opportunities for sharing expertise in small- and large-group discussions. For example, when developing strategies for preventing abuse, ask nurses to share how they have coped with a client displaying a difficult behaviour. Acknowledge the person's contribution. If you know that another participant has pertinent skills or experience, ask for her/his opinion on the issue.
- Enable learning by doing. Provide time for sharing with others and reflecting on the meaning of the material.
- Meet the needs and interests of the participants. Find out as much as you can through needs assessment, observation, discussion and by considering the work setting. Then, gear the learning activities to the participants' needs. Provide a follow-up activity that enables immediate application of what has been learned. For example, if a strategy for dealing with a client who behaves aggressively has been identified, ask for volunteers to try the strategy the next time they work with a client who behaves aggressively. Schedule a follow-up feedback session for the volunteers to report how the strategy worked.
- Encourage the participants to use their own work experiences in problem-solving and discussion. Pre-session activities, such as completing a questionnaire about values and beliefs or providing participants with an article about the topic, may help engage the learners.
- Leave the participants feeling positive about their learning experience. Tell

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the group how well they did. Acknowledge the risk-taking and problem-solving that occurred.

- At the end of each session, summarize the discussion and the outstanding issues that the group will follow up on.
- Suggest that participants watch for ongoing opportunities to learn more about the topic.

E. Dealing with Difficulties

The subject of abuse can generate a variety of responses from participants and may produce emotional or negative reactions. It is important that facilitators manage the potential reactions from participants and themselves.

- Be knowledgeable about methods to manage emotional situations and conflicts.
- Develop a list of local resources, including contact names and phone numbers, to assist nurses in managing their emotional responses. Resources to consider include:
  - Employee Assistance Program (EAP);
  - sexual assault centre;
  - crisis line;
  - reliable counsellors in the area; and
  - victim support groups.

Dealing with Emotional or Negative Reactions

Dealing effectively with problems in a group requires planning. The intervention model below outlines specific questions to help define the problem, select interventions and evaluate the outcome of the interventions.

An Intervention Model

Define the Problem

1. Issue
   - Why is this a problem?
   - What are its dimensions and its possibilities for affecting the group process?

2. Observations
   - What behaviours do I see taking place within the group and its members?

3. Diagnosis
   - What does the problem mean?
   - What understanding can I conclude about the behaviour from my observations and my grasp of the issues involved?

Address the Problem

4. Intervention Strategies
   - What are some of the specific techniques that I can use to enter the group's process to affect the problem?

Assess the Effects

5. Evaluation
   - What was the effect of my intervention?
   - How do I gauge my success or failure?

Common Difficulties

The following questions represent some of the common difficulties that facilitators face and possible interventions:

What do I do if someone expresses anger or disagreement with workshop content?

Step 1	Acknowledge the person's feelings. You might say, "You look really angry."
Step 2	Clarify the concern. You might say, "Help me understand what specifically you feel angry about."
Step 3	Correct any misunderstanding or misrepresentation.
Step 4	Have the person identify solutions/alternatives to the source of anger, if appropriate.

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Step 5 Solicit the group's feelings about the situation.

Step 6 Define strategies to deal with conflict (e.g., call or write CNO to express concerns with the program or address problems with a nurse-manager).

Step 7 Be prepared to agree to disagree.

What do I do when group members stray off the topic?

Step 1 Acknowledge the importance of the other issue raised by the members. Restate the objectives of the session and the time allotted to achieve them. You might say, "I can see that this issue is very important to you. However, we are here today to talk about ways that we can prevent client abuse from happening. We have 30 minutes scheduled for this session."

Step 2 Ensure that the person feels heard. One way is to use the "Parking Lot" method. Set up a flip chart that group members can use to "park" concerns that can be addressed at the end of the discussion or to form the basis of other discussions or in-services.

Step 3 It may be necessary to deal with the topic before being able to move on. Get group consensus. You might say, "This seems to be an important issue for the group. We can discuss this now and reschedule the in-service on abuse prevention for another time if you wish, or we can continue and set aside a specific time to deal with this issue at the end of the workshop or at another time."

Step 4 When a person repeatedly brings up the same topic, it may be useful to acknowledge it in the following way: "Mary, this issue must be very important to you. You have brought it up three times in the last half hour. I think that as a group we need to hear what Mary is saying. Is everyone listening? Mary, please tell us what specifically concerns you about this issue." Or, it may be necessary to explain to the participant that the group needs to move on and suggest meeting the participant later to discuss the issue.

What happens if someone becomes visibly upset and cries?

Step 1 Acknowledge that the participant is upset. You might say, "You must be really upset. Let's talk about it."

Step 2 Clarify the concern. You might say, "Help me to understand what it is, specifically, that you feel upset about."

Step 3 Be supportive. You might say, "I want you to know that I see your distress and I would like to help." Offer to meet the participant after the class. Avoid turning the session into an "encounter group." If the person leaves the room, ask someone to accompany the participant to ensure that she/he is okay.

Step 4 Follow up. Speak with the participant after the session. Ensure that

the participant has regained her/his composure and assess for any possible follow-up required.

What if someone discloses to the group that she/he has been abused?

Step 1 Indicate that you believe the person.

Step 2 Offer support. You might say, "This was obviously a very difficult thing for you to disclose. I would like to help you."

Step 3 Offer to meet with the participant after the session. Suggest seeking help from one of the local resources on the list that you have prepared.

If the person reports being abused by another health professional, you are obliged to report this in writing within 30 days to the alleged abuser's college, or immediately if you think the victim or other people are at risk of abuse. You must let the victim know about this obligation and ask permission to use the victim's name in the report. If you do not have permission to use the name, the report must still be filed but without the name.

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Mandatory Reporting

The *Regulatory Health Professions Act* makes it mandatory for all health professionals who have reasonable grounds to believe another health professional has sexually abused a client to file a report with the alleged abuser's college. The requirement applies to information learned while practising the profession. It is essential to tell participants at the beginning of each session that if they reveal that they or other nurses have sexually abused a client, you are obligated to report this information to the College of Nurses of Ontario.

This requirement may make your job as a facilitator more difficult and may inhibit some of the discussion, but it is essential to public safety.

What if someone discloses that she/he has sexually abused a client?

Step 1 Stop the participant from disclosing further. Advise the participant not to disclose any more information. Ask her/him to talk with you at the end of the session.

Step 2 Remind the participant about mandatory reporting requirements. Repeat, as you indicated at the beginning of the workshop, that you are obliged to report the information about sexual abuse to the College of Nurses of Ontario.

Step 3 Advise the participant to get help. You may want to refer her/him to counselling or the support services on your list. You may also recommend that the person seek legal advice.

What if someone discloses that she/he has abused a client physically, emotionally or verbally?

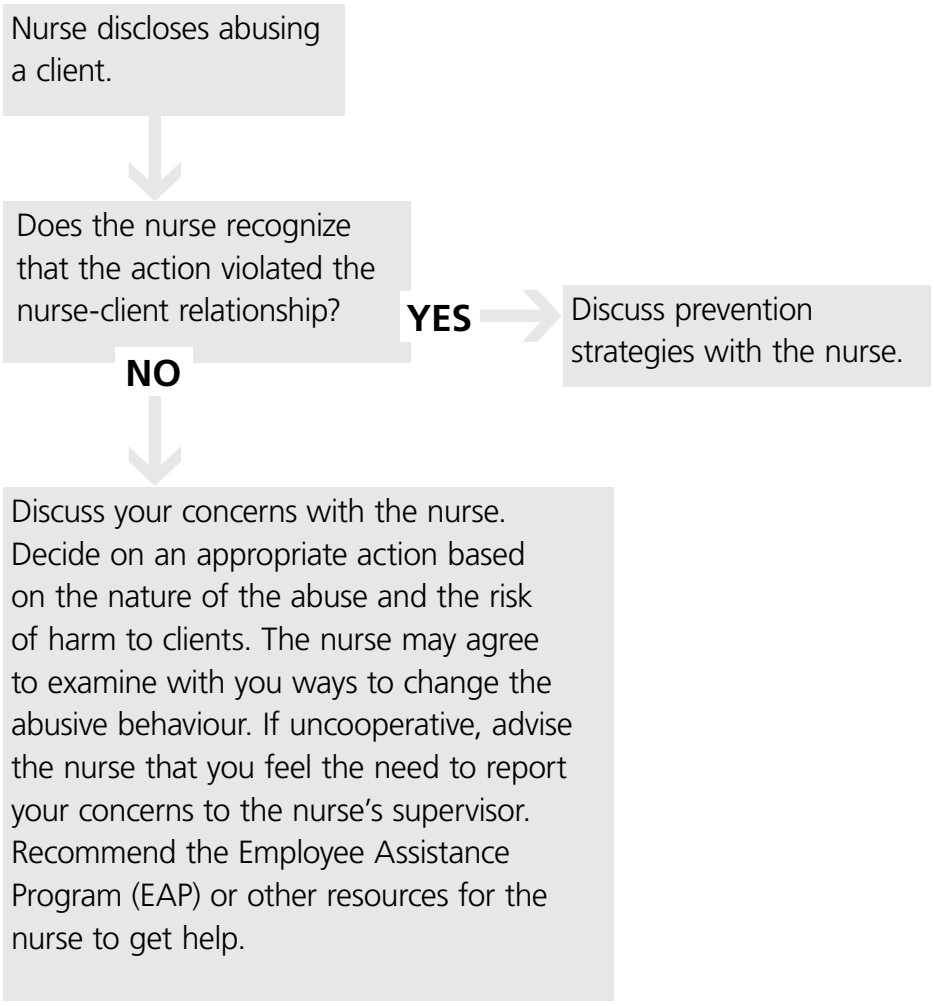
Step 1 Provide support for the nurse who disclosed the situation. You might say, "This is a very difficult thing to talk about. It took a lot of courage for you to share this." Ask to meet with the person after the session.

Step 2 Guide discussion away from the personal situation disclosed by the nurse. However, depending on the nature of the physical, emotional or verbal abuse, this issue may be used as a learning opportunity. For example, a nurse may reveal in the group that her strategy for managing the behaviour of clients who are constantly using the call bell has been to remove the bell. In the context of the session, she realizes that this may be considered abuse. Discussion could focus on different strategies to deal with clients who are constantly ringing for the nurse, rather than focusing on the fact that the nurse abused someone.

What if a participant does not acknowledge that her/his disclosed behaviours are unacceptable and considered physical, verbal or emotional abuse?

In this circumstance, the facilitator may be faced with difficult decisions. Reporting anything that is discussed in the group would breach the confidentiality promised to the participants. If you have concerns that clients could be at further risk from physical, verbal or emotional abuse by the nurse, you are accountable for intervening to protect the clients from harm. Consider the following decision tree:

Decision Tree



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Facilitator's Resources

Workshop Checklist

Activity	Person Responsible	Complete (month/year)
Several months ahead		
Review all materials included in the program		
Identify key audience and persons who can support the implementation of the program (e.g., managers, other educators, nursing administrators, staff). Discuss the abuse prevention program with stakeholders.		
Have stakeholders participate in planning a broad-based, long-term abuse prevention program for your setting.		
Consider organizing or putting together a working committee to develop the education program and generate ideas about strategies to prevent abuse on an ongoing basis.		
Book the rooms and audio-visual equipment as soon as you have set the dates and times.		
Develop a curriculum for each session using the learning modules in the guide. Review relevant policies and procedures in your organization.		
Make a list of the resources in your area to support nurses who may themselves have been victims of abuse.		
Four to six weeks ahead		
Distribute a flyer advertising the session. (See the Sample in Resource 3.) Post flyers in areas where there is a high traffic of nurses, but is out of sight of clients (e.g., the back of the door of the staff washroom). Post a sign-up sheet so you can estimate attendance, plan the session accordingly and know who should receive pre-session materials.		
Distribute pre-session reading materials, if you decide on this option.		
One week ahead		
Send reminders of sessions. Notices, e-mail, voice mail and staff newsletters are good vehicles. Talk about the session with your colleagues.		
Photocopy evaluation forms and other handout materials. Prepare overheads or flip charts, if needed.		

Activity	Person Responsible	Complete (month/year)
Day before		
Check the room: set-up, number of chairs, location of washrooms.		
Check audio-visual equipment.		
Collect all of the materials you will need (e.g., pens, paper, name tags or tent cards, tape, felt markers).		
Cue the videotape to where you want it to begin.		
Consider putting together a tool bag for all of your sessions. This could include: pen, markers, paper, masking tape, duct tape, stapler, staple remover, liquid paper, ruler, paper clips, scissors, pencils, highlighters, facial tissues, clip board, music tapes or anything you think you might require during the session.		
Day of		
Set up room prior to meeting with chairs in a circle or other format that allows for an informal, comfortable environment.		
Check that audio-visual equipment is working.		
Photocopy handout materials.		
Check supplies.		
Post signs directing people to session.		
Make a "welcome" sign on a flip chart or a chalk board.		
After		
Review evaluations and summarize for future reference.		
Meet with participants who indicated they want a one-on-one meeting.		
Send acknowledgement of participation to people who attended.		
Send evaluations to CNO.		

Adult Learning Resources for Nurses

There are many excellent adult learning resources that are tailored to the nursing environment. The following list, while not exhaustive, includes some of the materials reviewed during the revision of the *One is One Too Many* educational program. Because this program is based on case studies, the following bibliography also gives special attention to problem-based learning (PBL).

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Biley, F.C., Smith, K.L. (1998). The buck stops here: Accepting responsibility for learning and actions after graduation from problem-based learning nursing education and curriculum. *Journal of Advanced Nursing,* 27, 1021-1029.

Bastable, S.B. (1997). *Nurse as educator: Principles of teaching and learning.* Massachusetts: Jones and Bartlett Publishers.

Burton, A.J. (2000). Reflection: Nursing's practice and education panacea? *Journal of Advanced Nursing, 31* (5), 1009-1017.

Eisen, M-J. (2001). Peer-based professional development viewed through the lens of transformative learning. *Holistic Nursing Practice, 16*(1), 30-32.

Green, M.L., Ellis, P.J. (1997). Impact of an evidence-based medicine curriculum based on adult learning theory. *Journal of General Internal Medicine,* 12, 742-750.

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Hewitt-Taylor, J. (2001). Self-directed learning: Views of teachers and students. *Journal of Advanced Nursing, 36*(4), 496-504.

Morales-Mann, E.T., Kaitell, C.A. (2001). *Problem-based leaning in a new Canadian curriculum, 33*(1), 13-19.

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Flyer Mock-Up

Use the sample flyer (see over) for your sessions. Fill in the information and photocopy.

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

A program for learning how to prevent client abuse

ONE is ONE too MANY

Please join us to learn more about abuse prevention strategies in the workplace

Date:

Time:

Location:

Appendices

Notes

CNO Research on Client Abuse

Fact: The survey findings present a clear message that greater awareness of what is abuse = greater intervention by nurses to stop abuse = more effective abuse prevention.

As part of its continual efforts to help prevent the abuse of clients, the College collects information about abuse and abuse prevention in health care settings. Our major source of data is an independent telephone survey that asks Ontario nurses about their experiences with client abuse. The College has conducted three such surveys. These surveys involved a random sampling of 1,608 nurses in 1993, 1,000 nurses in 1997 and 1,027 nurses in 2005. The survey included RNs and RPNs. CNO has no knowledge of the individuals selected or any possible features which could identify specific situations.

The surveys looked at identifying the number of nurses who had witnessed or heard about incidents of abuse of clients by nurses and the context around these situations. The survey inquired whether nurses had witnessed or heard about nine types of abuse

- yelling or swearing;
- hitting or shoving;
- roughness;
- embarrassing or offensive comments;
- deliberately ignored care needs;
- sexual assault or harassment;
- taking something valuable from a patient (2005 only);
- abuse by a non-nurse health care provider; and/or
- other (open responses).

The questions about the context of the incident(s) included:

- frequency of abuse incidents witnessed;
- type of practice setting;
- gender, approximate age, mental and physical condition of the client;
- characteristics of the nurse involved (category, sex, age, years in practice);
- actions of observers or the client; and
- outcome of the incident (e.g. report);

Overall Findings

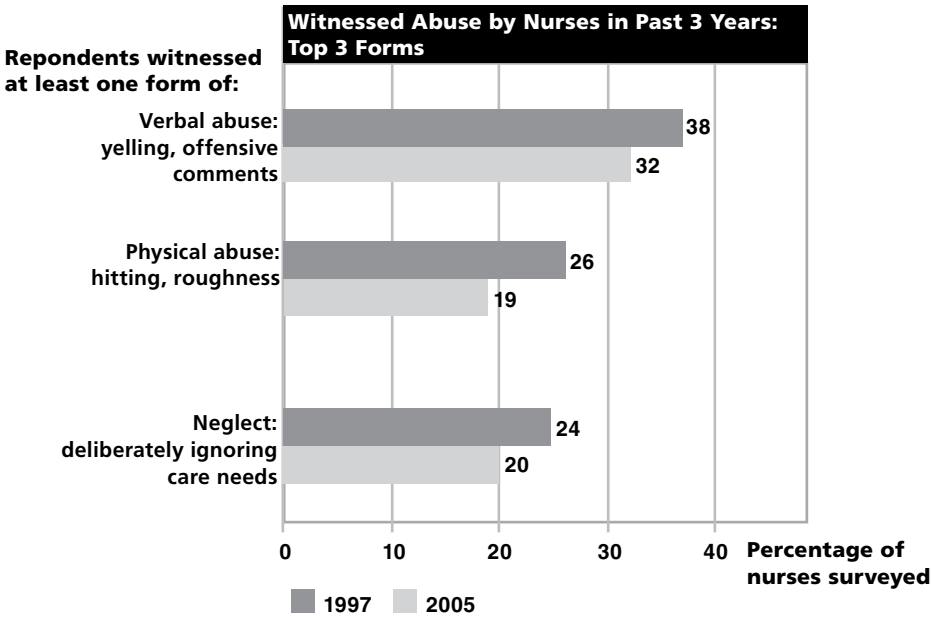
Nearly half of all nurses surveyed reported witnessing or hearing about client abuse by a nurse. From 1993 to 1997 there was a small increase in nurses seeing or hearing of abuse by other nurses. In 2005, however, there was a significant decline. In the 1997 survey, 48% of respondents reported witnessing abuse and 11% reported hearing about abuse. In 2005, fewer nurses had seen abuse (40%) or heard of abuse (9%) by other nurses.

Distribution of Types of Abuse Witnessed or Heard (2005 data)

Embarrassing or offensive comments 29%
Yelling or swearing 23%
Deliberately ignoring care needs 23%
Roughness. 21%
Abuse by a non-nurse health care provider 15%
Hitting or shoving 5%
Other 4%
Took something valuable 3%
Sexual abuse 2%

Top Three Forms of Abuse Witnessed by Nurses in Past Three Years Comparison 1997 & 2005

The 2005 research showed a significant decrease in the proportion of nurses who witnessed verbal abuse, physical abuse and neglect over the past three years. Verbal abuse continues to be the most common type of abuse followed by physical abuse and neglect. Verbal abuse includes "a nurse making comments about a patient which were embarrassing or offensive" and "a nurse yelled or swore at the patient."



Note: Nurses who witnessed more than one form within a category of verbal or physical abuse measures are counted as a one.

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Setting

The highest awareness of abuse by nurses is at long-term care facilities (53%), followed by hospitals (43%), psychiatric hospitals (40%) and community settings (25%).

The table below shows data for various types of abuse (over time) by the respondent's place of employment.

Abuse By Nurses: Percentage of Nurses Who Witnessed Abuse in Past Three Years by Employment Setting

	Hospital		Long-Term Care		Community		Psychiatric Hospital	
	1997 %	2005 %	1997 %	2005 %	1997 %	2005 %	1997 %	2005 %
Verbal abuse	54	47	**77**	58	**35**	25	**66**	52
Physical abuse	**32**	23	**44**	26	**20**	13	**38**	21
Neglect (ignoring needs)	24	21	35	28	17	15	26	22
Sexual abuse		1		2		2		1
Financial abuse	N/A	1	N/A	3	N/A	2	N/A	1
Other	5	3	12	7	8	4	7	6

Note: A of a 1997 percentage in bold indicates that it is significantly different from the 2005 figure.

There are significant differences by the nurses' place of employment. Nurses in long-term care settings are more likely to state that other regulated professionals (13%) or unregulated health care workers (52%) are the abusers; those in psychiatric settings are more likely to name RPNs (41%), and those in hospitals to name RNs as the abuser (62%).

Frequency

Those nurses reporting witnessing or knowing about abuse were asked how many instances of client abuse they were aware of:

one 24%
two 24%
three 13%
four or more 30%

Client Characteristics

Gender

The victim was more often female: 61% female vs. 39% male. In psychiatric institutions, however, the client was more likely to be male: 54% male vs. 46% female.

Age

Most abused clients (67%) were age 65 and older, and most of these (45%) were age 75 or older.

Condition

Clients when abused were reported to be:

- stressed (73%) vs. relaxed (27%)
- confused (52%) vs. alert (48%)
- medicated (52%) vs. not (48%)
- not able to speak clearly (31%) vs. able to speak clearly (69%)
- in pain (38%) vs. comfortable (62%)
- confined (27%), assisted movement (48%), unassisted movement (25%)

Between 1997 and 2005, there was an increase in the proportion of clients who could speak clearly and move with assistance.

Familiarity with Abuser

The majority of abused clients (64%) knew the abuser moderately well or very well. This is a decrease from 1997 when 79% of abused clients knew the abuser moderately well or very well. In 2005, 27% of abused clients knew their abuser very well—decline from 33% in 1997.

Actions of Abuse Observers

In the majority- of abuse cases (63%) someone else saw the abuse take place. A third party saw the abuse and requested that the behaviour stop in 33% of these cases, while 24% said that the witness to the abuse did not ask that the behaviour stop, and 6% did not know if the abuser was asked to stop.

Did the abuse stop when someone intervened? The results show that observers are increasingly effective in getting the behaviour to stop. In 2005, 88% of those who said the observer asked the abuser to stop say the abuse stopped. The rate of effectiveness is significantly higher than it was in 1997 (78%). Observers are more successful than clients in getting the abuse to stop.

When abuse occurs, clients are not likely to speak up. Only 21% of clients spoke up about the abuse. However, most clients succeeded in halting the abuse once they spoke up.

Reporting of Abuse

Of the incidents cited:

- 45% were reported to the employer;
- 6% to CNO; and
- 4% to CNO and the employer.

While CNO requires that sexual abuse be reported to the College, it is not mandatory to report other types of abuse to the College. Abuse must, however, be reported to either the employer or CNO. Respondents offered a variety of reasons for not reporting abuse to CNO. The most prominent reason was that the incident was handled by the employer, the abuse was not severe enough and the abuse wasn't by a regulated health care worker.

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Factors which May increase the Risk of Client Abuse

CNO's research into abuse prevention (Appendix 1) found that there are factors that increase the risk of clients being abused. Assessing the extent to which these factors exist in your practice setting will help guide your abuse prevention efforts.

1. Characteristics of Clients

The reported characteristics of abused clients indicated that those who are "vulnerable" are more likely to be abused. Clients who are most at risk for being abused are:

- elderly (65+);
- women;
- in poor condition; and
- clients who are under a lot of stress.

The majority of abused clients knew the abuser moderately well or very well. Verbal abuse is the most common type of abuse experienced by clients, in the form of embarrassing comments and yelling or swearing.

2. Setting

Long-term care and psychiatric care settings were found to be the practice settings where abuse most commonly occurred.

3. Characteristics of Nurses

Nurses who abuse clients do not fit one description. However, nurses who are overworked, tired, or stressed due to working conditions, or those who are coping with difficult personal problems are most at risk.

4. The nurse, client, client's family, or visitors are reluctant to report the incident.

5. Nursing colleagues are reluctant to intervene in situations of potential client abuse.

Intervening and reporting abuse is essential to stopping abuse. **Abuse stops when a nurse intervenes**.

If any of these factors are present in your practice setting, you can take action to address them. Consider the following questions.

- Are there unacceptable stresses in the workplace (e.g., poor staffing levels and mixes, inadequate supervision)? How can they be addressed?
- Are there effective supports for nurses who are undergoing personal stress (e.g., Employee Assistance Programs)?
- What supports are there to promote regular continuing education and refresher programs on strategies for dealing with workplace stresses?

- What supports are available to promote positive working relationships and permit effective intervention by nurses in potentially or actually abusive situations?
- What is being done to inform clients of their rights and/or provide clients with the supports to report incidents of abuse? Is there something that can be done for the client if they have experienced abuse by a health care provider?
- Are nurses supported by their unit leaders, management, and colleagues when they report abuse?

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