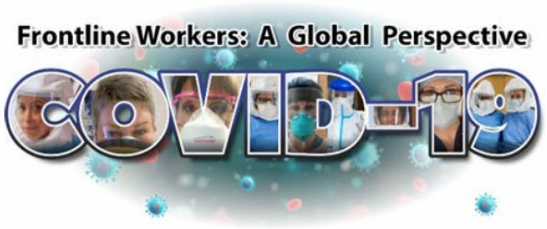


Frontline Worker Safety in the Age of COVID-19

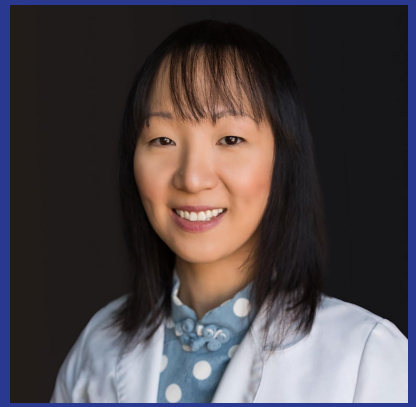
Health Watch USA[sm]

Webinar Sept. 14th, 2022 - Registration Now Open

https://healthconference.org

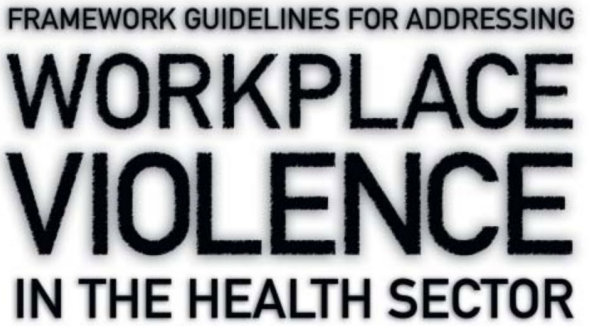
Workplace Violence in Healthcare

Zed Zha, MD



What constitutes WPV?

World Health Organization (WHO):



Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health. (Adapted from European Commission)

Psychological violence

Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats. (Adapted from WHO definition of violence)

US Department of Labor Occupational Safety and Health Administration (OSHA):

“WPV is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.”

“It can affect and involve workers, clients, customers and visitors.”

“WPV ranges from threats and verbal abuse to physical assaults and even homicide.”

REVIEW ARTICLE

Work

Table 1. Types of Workplace Violence.*

Type	Description	Example
I	Perpetrator has no association with the workplace or employees	Person with criminal intent commits armed robbery
II	Perpetrator is a customer or patient of the workplace or employees	Intoxicated patient punches nurse's aide
III	Perpetrator is a current or former employee of the workplace	Recently fired employee assaults former supervisor
IV	Perpetrator has a personal relationship with employees, none with the workplace	Ex-husband assaults ex-wife at her place of work

* Data are from Howard[4] and Peek-Asa et al.[5]

Prevalence of WPV against HCWs

Worldwide, pre-pandemic

2020 Meta-analysis 253 studies, 331,544 HCWs, in the past year (before Oct 2018):

61.9% reported exposure to any form of WPV

42.5% reported exposure to non-physical violence

24.4% reported experiencing physical violence

Verbal abuse (57.6%) was the most common form of non-physical violence, followed by threats (33.2%) and sexual harassment (12.4%).

Worldwide, pre-pandemic, continued

2019 Meta-analysis of 980 articles (between Jan 1992 and Aug 2019):

Verbal abuse up to 59%

Physical abuse up to 22%

Sexual harrassment prevelent in dentistry, up to 54%

-Nigerian survey study (2011): prevalence of WPV 32% in oral health

-female predominant staff, long wait time, patient volume, care outcome

-18% of such violence is physical, note easy access to sharp instruments

Hidden Pandemic

India: COVID-19 care/contact tracing related violence against HCWs on the rise, the government has made violence against HCWs an offense punishable by up to 7 years imprisonment.

Germany: severe aggression or violence has been experienced by 23% of primary care physicians.

Spain: there has been an increase in the magnitude of the phenomenon in recent years

UK: 56,435 physical assaults on staff in 2016–2017.

Italy: in one year, 50% of nurses were verbally assaulted in the workplace, 11% experienced physical violence, 4% were threatened with a weapon

Poland, Czech Republic, Slovakia, Turkey: many nurses have been physically attacked or verbally abused in the workplace

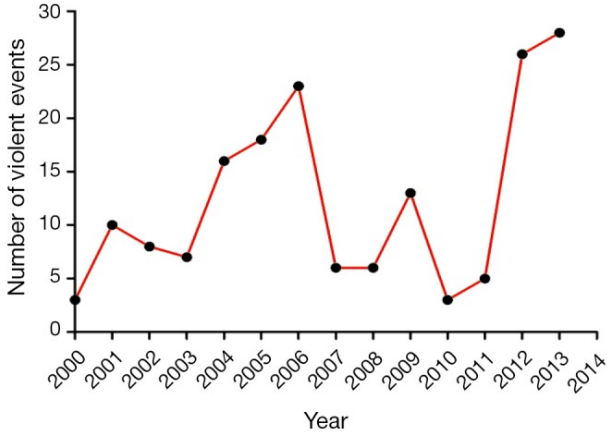
South Africa:, over 30 hospitals reported serious security incidents in just 5 months in 2019

Iran: physical or verbal workplace violence against emergency medical services personnel is 36 and 73%

Thailand: 54%

Morocco: 70%

PR China



Since 2000, V

2012: 7 were

non-physical

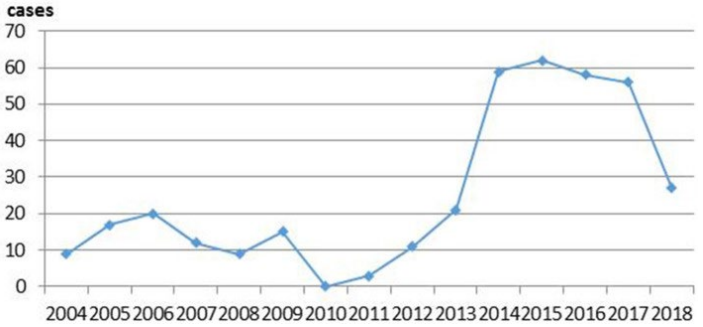
physical abu

assaults/h

Zeng Q, Peng M, Ren S, Chen G, Wang J. iolence against medical workers in China. J c Dis. 2014 Jun;6

2020 survey 15.9% of which were physical assaults.

PR China: casualties



Ma et al. Serious Workplace Violence Against Healthcare Providers in China Between 2004 and 2018. Front Public Health. 2021 Jan 15

265 reports of serious injuries between 2004 to 2018

13% resulted in deaths (N=34)

6% severe injuries: pierced heart, paralysis of both lower limbs, decapitated arm, or intestinal perforation

26% “minor” trauma: intracranial hemorrhage, orbital fracture, concussion, miscarriage, second-/third-degree burn, tendon rupture, or lung contusion

31% “slight” injuries: light closed encephalon injury, threatened miscarriage, soft tissue contusion, nose bleeding, head trauma, facial blood stasis, or waist injury

How has the pandemic impacted this trend?

March - September, 2020

>600 cases of intimidation and stigma against nurses were reported in 40 countries. (Red Cross)

Meta-analysis of 17 studies, 17,207 participants:

Physical violence: 17%

Non-physical violence: 44%

Among nurses: 47%

Among physicians: 68%

May to July, 2021

Survey (the International Council of Nurses + the International Committee of the Red Cross + the International Hospital Federation + the World Medical Association): 33 organizations

Figure 4. Percieved increase in reported cases

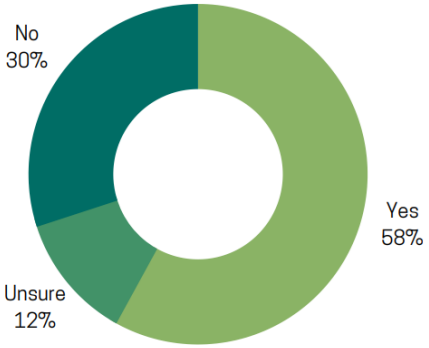


Figure 1. Geographic distribution of responders

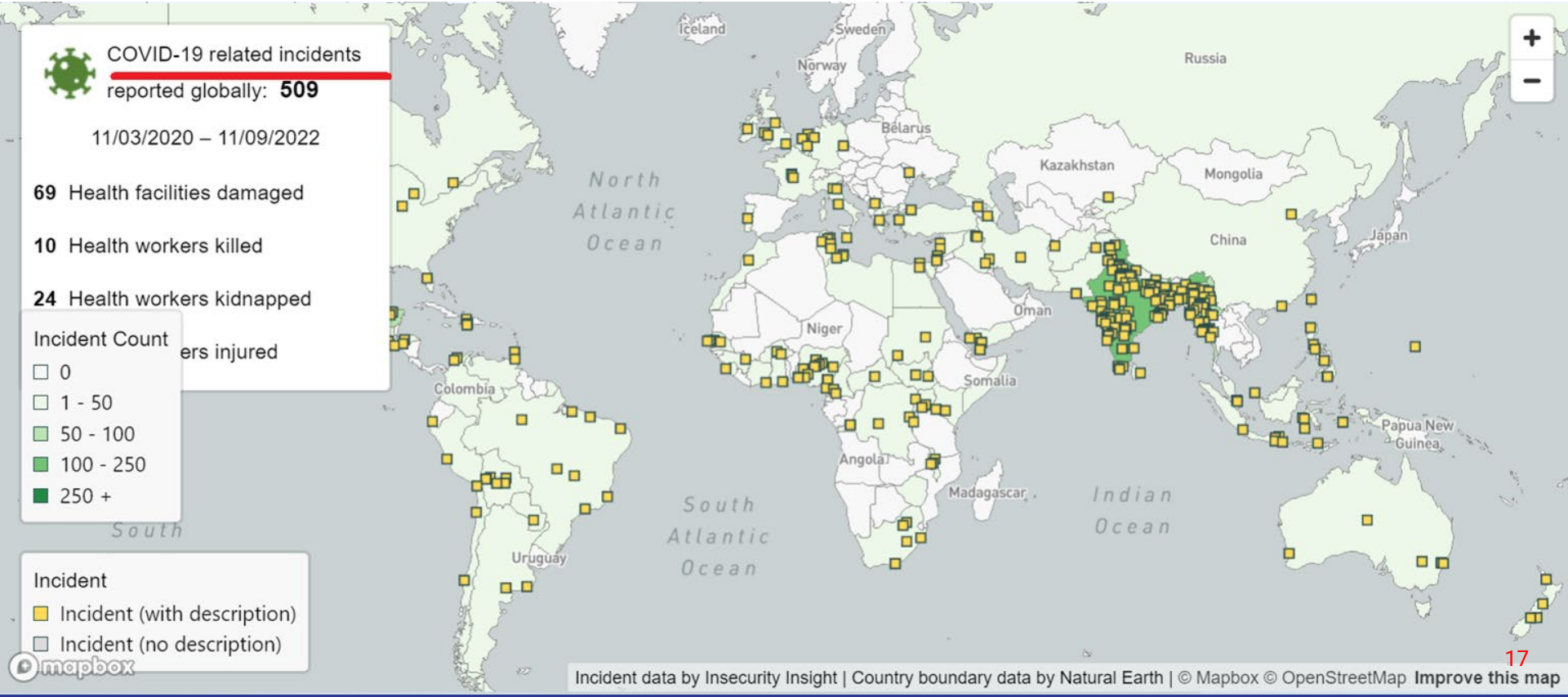
April, 2022

In the month of April, 2022 (Perceptyx survey, 1,095 participants): 9 in 10 have experienced/been in close proximity to violence from a patient or a patient's caregiver

3 in 4 have encountered both verbal and physical assaults

nearly 50% needed to call for security or another coworker to assist.

A Hidden Pandemic, continued



Who are the victims?

Departments

Emergency Departments

Mental Health Units

Drug and Alcohol Clinics

Ambulance services

Dentistry

OB-GYN (China data)

Nursing homes/LTCs

Settings

Remote health care areas

High crime areas

Small and isolated

Understaffing

Emotional or mental stress of patients or visitors

Insufficient security

Lack of preventative measures

Poor communication/leadership/intimidation culture

But…(2019 meta-analysis of 13 articles):
“Most doctors were susceptible to type II WPV regardless of their work environment, organizational culture and structure, and access to resources.”

Risk groups: WHO

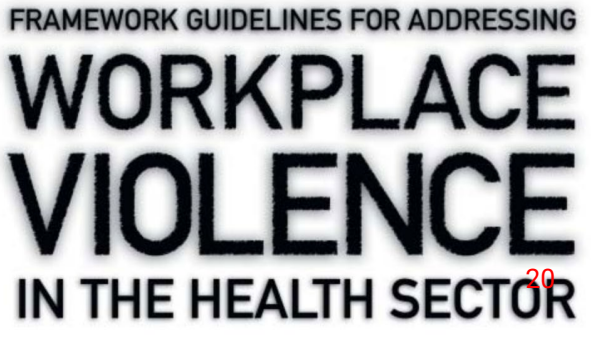
Female > Male HCWs, especially sexual harrassment (most studies)

Members of minorities

People in training/inexperienced workers

Young people

?name tag/uniforms



Racially motivated violence on rise

Even more disturbingly, though racially and ethnically motivated violence is not new, reports of verbal and physical abuse by white supremacists attacking the personal characteristics of health care professionals from historically and racially marginalized groups represents a deeper layer of racism.

Early in the pandemic, the AMA warned that xenophobic language around the SARS-CoV-2 threatened to further fuel discrimination and hate crimes specifically against Asian Americans, which were already a significant concern due to long-standing interpersonal and structural racism.

But as researchers have pointed out, while general workplace violence across health care is well-documented, such incidents rooted in racism like the one recently in Boston are too often decontextualized and classified as "disruptive" rather than racial violence. This, the authors (PDF) tell us, "represents a violent avoidance, silence, and complicity to the insidious nature of white supremacy, which is deeply embedded in the structure and culture of medical institutions."

Racial Harassment (WHO)

Any threatening conduct that is based on race, colour, language, national origin, religion, association with a minority, birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work. (Adapted from Human Rights Act, UK)

Anti-AAPI Hate during the pandemic

6% US population are AAPI, yet

20% non-surgeon physicians and pharmacists

12% to 15% of surgeons, physical therapists and physician assistants

Prior to pandemic: 31% to 50% of AAPI physicians experienced on-the-job discrimination (lower than Black physicians but higher than other groups)

Since pandemic:

- Police reports of anti-Asian hate crimes shot up 146% in 2020, while hate crimes overall rose 2%
- 1 month survey study 4.2020: only 1% of non-AAPI HCWs reported experiences of racism, 20% Asian HCWs reported racism during the same time frame

What are the reasons for serious attacks?

Overall

Mental illness: dementia, schizophrenia, anxiety, acute stress reaction

- Dementia: 87% of physical assaults of nursing home assistants
- Male patients with dementia > female patients with dementia

Drugs and ETOH:

- (2001, 2004) 35%-96% of healthcare workers believed that the violent perpetrator was using drugs or alcohol prior to the violent event

Patients' and visitors' inability to deal with a crisis situation:

- disagreements with the medical plan
- denial of a service or request, conflict with healthcare workers
- excessive waiting for assessments and interventions
- perceptions of a healthcare worker as rude or uncaring
- grief over the death of a child
- lack of control over the ability to change a healthcare outcome

2004-2018 Chinese data (Ma, et al)

Dissatisfaction with Care

refusing to accept the death of the patient (13%)

being dissatisfied with the treatment outcomes (11%)

Unreasonable Requests

thinking that the emergency treatment is not effective (7%)

wanting to get treatment as soon as possible without following medical procedures (7%)

Mental health/intoxication

having a suspected/confirmed mental disorder (4.5%)
being drunk (4%)

believing that adverse effects of treatment were due to clinical operations (3%)

failure of operation leading to the need for a second operation (3%)

asking staff for particular treatment and arrangements but being refused (1%) others (20%)

Who are the perpetrators?

Minnesota nurse data (2004, n=79,128 RN/LPNs)

73% verbal violence: men between age 35-65

59% physical violence: men, 64% of these were by men 66 years or older

~5% by people younger than 17

Serious physical attacks (2004-2018 Chinese data)

relatives of the patients 57%

Patients 40%

Both 4%

Non-relatives of patients 8%

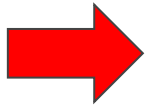
What was done?

Most people did not take any action to deal with the violence.

- 2009 Brizil, 254 surveys: 9% reported sexual harrassement, 0 filed complaints
- 2015 US, 446 surveys: 62% prevalence of WPV, but 88% under-reported
- 2021 China, 324 surveys: 65% prevalence of WPV, 25% formally reported
  - 50% said either no reporting system or didn't know how
  - 51% under-reported incidents, nurses felt hospital paid more attention to the patients than staff

Why the discrepancy? OSHA+research:

The perception that violence is “part of the job”.



Trivialization

The fear of retaliation (when reporting a co-worker).

A lack of training in violence prevention.

The lack of a reporting system – or lack of faith in the reporting system.

The lack of effective means of emergency communication.

Taboo, fear of appearing incompetent.

Case

2015.7.15, 9 am, Longmen, Guangzhou, China

36-year-old female neurologist was rounding in the hospit male patient showed up stating she saw him 1 year ago, and would like to have her see him again. Victim agreed to see perpetrator after rounds. Perpetrator pulled out a kitchen cleaver, stabbed the victim multiple times.

Surveillance video capture the whole event, which was publicly accessible.

2015.12. Perpetrator was deemed to be mentally stable, able to take full responsibility of actions at the time of the tragedy, sentenced for 2 years in prison.

What did the public say?

Research article | Open Access | Published: 19 May 2017

Microblogging violent attacks on medical staff in China: a case study of the Longmen County People's Hospital incident

Jia Tian & Li Du

BMC Health Services Research **17**, Article number: 363 (2017) | Cite this article

664 micro-blog posts were analyzed

56% showed sympathy for the injured physician

23% explicitly condemned violence

43% did not contain any emotional expressions in regards to the incident

10% expressed regret in entering medical professions and intending to quit

3 recalled their experience at the hospital, criticizing its poor medical conditions and doctors' irresponsible attitude

2 blamed the doctors' bad medical performance and attitude in general, even supported to the patient's attack

0 from legal or administrative authorities

What happens next?


impaired functioning
leave day
decreased staff retention
death
defensive medicine
depression
burnout
reduced interest
dissatisfaction
injury
ptsd
ethical value
lower patients safety

The Great Resignation

Washington Post - Kaiser Family Foundation survey (2021):

30% HCWs are considering leaving their profession

60% reported impacts to their mental health stemming from their work during the COVID-19 pandemic

U.S. Bureau of Labor Statistics (accessed 9/4/2022):

2nd quarter of 2022, 1.6 million people have quit their jobs in the “Health care and social assistance” category.

Lessons from China’s data

2020 Chinese survey:

Less than 1 in 4 would have gone into medicine if knew the risks.

More than 9 in 10 will talk their children out of going into medicine.

Predictions in the US

Association of American Medical Colleges:

By 2034, US shortage of physicians → between 37,800 and 124,000.

American Association of Colleges of Nursing:

In 2029, US needs an additional 221,900 registered nurses to fill the workforce demand.

Mercer:

By 2025: US faces a shortage of more than 650,000 other healthcare workers

By 2026: this increases to 3.2 million…

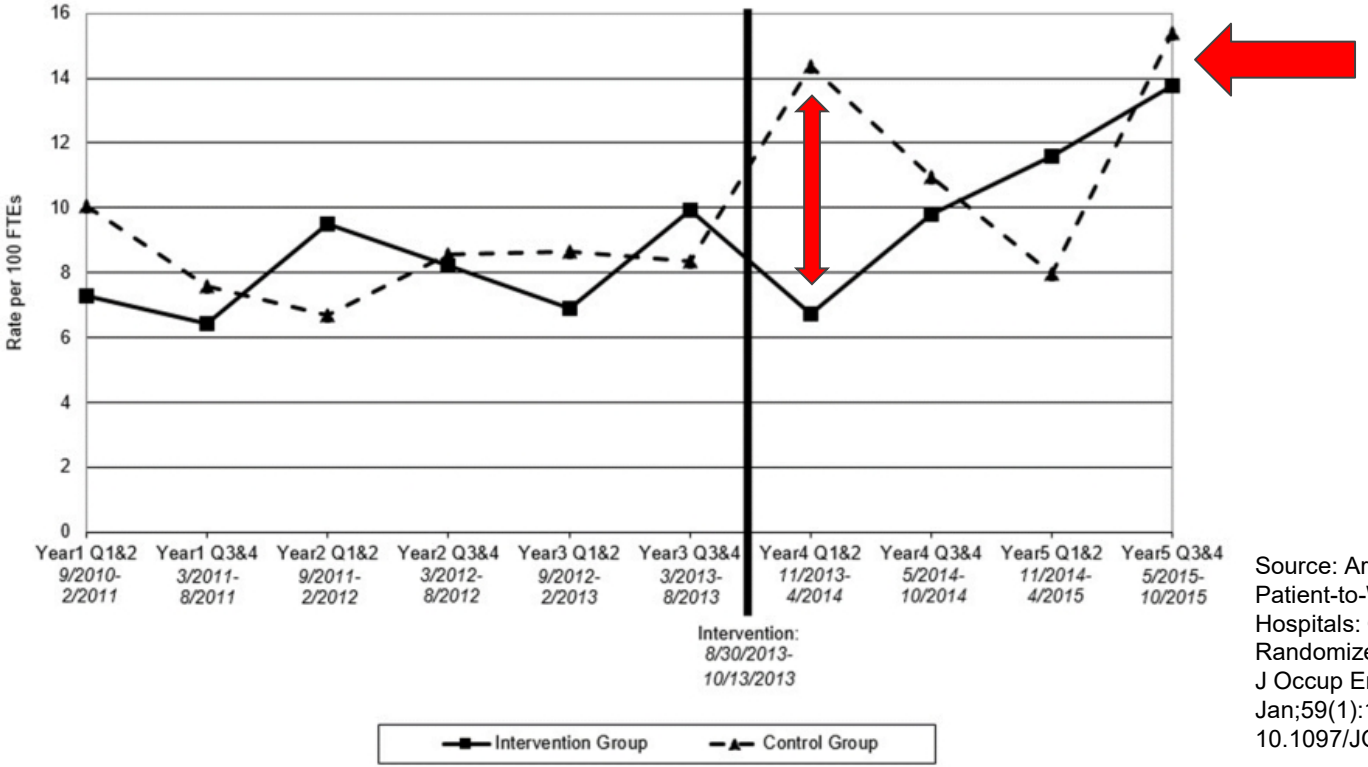
What needs to be done?

Prevention: does it work?

The study results are conflicting for implementation of prevention programs.

2017 US RTC across 7 hospitals, 5 years (3 pre-intervention+2 post-intervention):

- Phase 1: Development of standardized reports of workplace violence
- Phase 2: Implementation of the Hazard Risk Matrix to prioritize hospital units for intervention
- Phase 3: Randomized intervention
  - Rounding with research team x 1 time to study safety data
  - Coming up with Action Plan
- Phase 4: Intervention evaluation (6, 12, 18, 24 months survey evals)



Source: Arnetz et al. Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention. J Occup Environ Med. 2017 Jan;59(1):18-27. doi: 10.1097/JOM.0000000000000909.

Figure 2

Rates of violent events per 6-month intervals, Intervention and Control units, 36 months pre and 24 months post-intervention.

Intervention period: August 30, 2014 -October 13, 2014

Rates = number of incidents/100 full-time equivalents (FTEs)

De-escalation

Training programs ranging from a few hours (workshops) to a few weeks (workshops, simulations, etc), while increase HCWs confidence in responding to WPVs, don't seem to overall decrease prevalence.

What works?

Multicomponent interventions, involving all stakeholders.

- Clearly define violence, identify high risk units, panic buttons, security locks
- Policy changes (involving administration)
- Training by professionals

Post-incident

Reporting system

Root-cause analysis

Reflection / debriefing

Organizational support and assistance to the victims

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Legislation

Legislation | Examples: hr5, sres9, "health care"

MORE OPTIONS

Home > Legislation > 117th Congress > H.R.1195

Citation

H.R.1195 - Workplace Violence Prevention for Health Care and Social Service Workers Act

117th Congress (2021-2022) | Get alerts

BILL Hide Overview ✕

Sponsor: Rep. Courtney, Joe [D-CT-2] (Introduced 02/22/2021)

Committees: House - Education and Labor; Energy and Commerce; Ways and Means | Senate - Health, Education, Labor, and Pensions

Committee Meetings: 03/24/21 12:00PM

Committee Reports: H. Rept. 117-14

Latest Action: Senate - 04/19/2021 Received in the Senate and Read twice and referred to the Committee on Health, Education, Labor, and Pensions. (All Actions)

Roll Call Votes: There have been 2 roll call votes

Tracker: Introduced | **Passed House** | Passed Senate | To President | Became Law

Newest challenge: Active Shooter/Gun Violence

Dr. Preston Phillips,

Dr. Stephanie Husen,

receptionist Amanda Glenn,

and the husband of a patient, William Love

References

II.9 VIOLENCE IS A CONTAGIOUS DISEASE[6]

Gary Slutkin, M.D.

The University of Illinois at Chicago

Cure Violence (formerly CeaseFire)

Violence is a contagious disease. It meets the definitions of [illegible] violence is spread from one person to another. This pa[illegible] torically by its natural history and by it[illegible] ework—and how we ca[illegible] e; and (3) [illegible] able results, [illegible] ific and policy [illegible] processed, and begins to outline [illegible] icies and longer term situations.

But what happens when the infected ones are the healers themselves?

The science, and the public understanding that follows this science, are bringing us into a new era. This new era is an era of *discovery*—but more importantly of *transition*. We can now leave the days of a vocabulary of "bad people" and "enemies" and apply a scientific understanding and a scientific approach to this problem. Violence has all of the historical, population, and individual characteristics of an infectious disease. It has routes of transmission, incubation periods, and different clinical syndromes and outcomes. There are definable biological processes underlying the pathogenesis. In addition, treatment as an infectious disease is effective. All of this requires more refinement and research. We are still performing research and refining our approach with tuberculosis, cholera, and malaria as well, but at least we have taken these problems out of the moral, medieval, and superstitious realms of evil and dungeons.

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