Editorial

Violence Against Healthcare Staff – A Multidimensional Problem

Aidan L Tan, [1]*MBBS*, Gabriel SZ Chia, [2]*MBBS*, Beng Yeong Ng, [3]*MBBS, M Med (Psych), FAMS*, Yuke Tien Fong, [1]*MBBS, MSc (Occupational Medicine), MBA*

Aggression and violence is prevalent in healthcare, with rates of 60% worldwide.[1,2] Potentially, 70% of Singapore's hospital staff have experienced physical abuse,[3,4] given significant under-reporting.[5] With increasing demand on healthcare services, recognition and management of this problem is essential.

Definition

The Workplace Safety and Health Council defines workplace aggression[6] as being not limited to physical violence, or to the geographical worksite. It is any abuse, including verbal, physical or emotional abuse and sexual harassment of healthcare providers resulting in injury, psychological harm, mal-development or deprivation. This is commonly termed "healthcare violence". Perpetrators may be patients or relatives against staff,[3] or between staff members.[7]

Healthcare Violence Effects

Victims may suffer physical harm and acute and chronic psychosocial effects, for example, post-traumatic stress disorder, depression and burnout. Reluctance to continue healthcare-related work may occur.[8,9] It can reduce employee productivity, increase medical benefits and sick leave use and result in legal costs.[10] Institutions with increased aggression against staff may develop poor professional and societal reputations. Decreased workforce morale and job satisfaction would further reduce their ability to attract and retain staff.[8,11] Perpetrators may suffer poorer care, potential caregiver abuse[11] and increased restraint use.[12,13]

Risk Factors

Incidents occur more commonly in certain profiles and environments.[7,10] Staff factors include: recently employed, younger female staff or those with greater patient contact, for example, nurses or frontline staff, and those in intensive care, mental health and emergency units. [7,13]

Older male patients, or those with neuropsychiatric disorders, drug or alcohol intoxication are more likely to perpetrate violence.[7,13] Personality and social issues, such as unmet expectations, negative perceptions of healthcare providers and difficult circumstances predispose to aggression.[7]

Environmental factors encompass the physical environment,[14] such as the provision of escape routes and protective equipment, effectiveness of crowd-control barriers and the workplace environment. This includes adequacy of manpower allocation, workplace culture supportiveness, training opportunities provision, and security presence.[6,7]

Managing Healthcare Violence

Management of healthcare violence requires institutional and national involvement, via multiple approaches. The approach adopted could be similar to infectious disease outbreak management: with case surveillance, treatment of affected individuals and incident investigation. Case surveillance includes risk management database creation and maintenance, with institution of staff reporting requirements. Treatment should cover medical and psychological support, with adequate leave, job-scope adjustment[3,6,9] and worker injury compensation as necessary.[15] Incident investigations and root-cause analysis should be conducted for preventive or control measure implementation.[3,6]

Alternatively, the hazard-management approach may be adopted. This involves identifying violence as a hazard and implementing preventive measures according to the hierarchy of controls.[16] Elimination or substitution level policies are on a national scale, constituting nationwide education on appropriate behaviour and punitive measures. Engineering controls involve the built environment: creating protective barriers and escape routes for staff, providing appropriate furniture arrangement, reducing isolated or

[1]Preventive Medicine, National University Hospital, Singapore
[2]Occupational Medicine Unit, Singapore General Hospital, Singapore
[3]Department of Psychiatry, Singapore General Hospital, Singapore
Address for Correspondence: Dr Aidan L Tan, National University Hospital, 1E Kent Ridge Road, Tower Block, Level 6, Singapore 119228.
Email: Aidan_lyanzhiang_tan@nuhs.edu.sg

enclosed areas[14] and placing visible security presence, ensuring adequate crowd control and limiting workplace accessibility.[3,6]

In patient-interaction areas, these measures should be balanced against other considerations, for example, easing staff-patient communications, and this may be modified for a more welcoming atmosphere.

Administratively, staff training and education should be provided. Topics should include: acceptable behaviour by patients and family, avenues for surfacing issues, personal precautions and recognition and response to violence, for example, de-escalation skills.[3,6,17] Adequate manpower allocation to match service demand while providing a "buddy" system and visible security presence are also appropriate. Managerial support for staff feedback and "zero-tolerance" policies should be actively enforced. Lastly, personal protective equipment, for example, alarm buttons, should be utilised.

These approaches are not mutually exclusive and should not be implemented as such. Healthcare violence has strong social components and requires governmental involvement. Legislation for worker protection with changes to the public-at-large,[15] is recommended.[6,17]

In Singapore, portions of these methods have been implemented and institutional measures targeting certain risk factors or profiles are being utilised. Nationally, the Protection from Harassment Act[18] was revised in 2009 to protect healthcare providers. These are in keeping with recommendations from the Occupational Safety and Health Administration.[17]

However, all of the above measures are reactive and one-sided. Responsibility is placed upon staff and institutions to protect themselves during incidents, with few avenues for punitive measures to be visited against abusers. Investigations address only staff or institutional issues and ignore social or patient components. The importance of social and patients' expectations is underscored in light of China's healthcare violence incidents.[19,20]

Management of healthcare violence needs to look at the social components in order to understand and thereby, alter behaviour. Undoubtedly certain factors are immutable, but others, for instance, social norms and expectations are important to address. Unmet expectations is a recognised factor.[7,20] Management of this includes both raising healthcare quality to realistic and acceptable standards and tempering unrealistic expectations. A second factor is social norms. Staff need to recognise that violence is neither "part of the job" nor socially acceptable. The public needs to recognise violence as a problem, thereby denying it social credence and legitimisation, while making abusive behaviour socially unacceptable. Self-policing through mechanisms such as social stigmatisation and acceptance of punitive measures against perpetrators should be encouraged.

Identification of issues is easy. The difficulty lies in implementation. Singapore has undertaken important educational first steps such as encouraging media coverage via televised drama serials ('You Can Be an Angel Too') regarding the nursing profession and placing posters highlighting the issue ('Our Staff Are Precious Too') in public areas. Like managing smoking or obesity, issues with social-behavioural components are difficult to change. Further research should be undertaken in order to aid control and prevention efforts.

Conclusion

A population under stress from illness and disease will inevitably have difficult cases with some level of behavioural issues. In order to prevent and control incidence, measures aimed at altering behaviour and social norms need to be implemented together with providing protective policies for those at risk. Resolving this issue will be a long road involving multiple agencies across all levels, requiring a major shift in society's perception and expectations.

REFERENCES

1. Schulte JM, Nolt BJ, Williams RL, Spinks CL, Hellsten JJ. Violence and threats of violence experienced by public health field-workers. JAMA 1998;280:439-42.
2. Di Martino V. Workplace violence in the health sector - Country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study: Synthesis Report [Internet]. World Health Organisation; 2012. Available at: http://who.int/violence_injury_prevention/violence/activities/workplace/WVsynthesisreport.pdf?ua=1&ua=1. Accessed on 2 October 2015.
3. Chan AO, Chan YH, Kee JP. Exposure to crises and resiliency of health care workers in Singapore. Occup Med (Lond) 2013;63:141-4.
4. Singapore Medical Association. Violence in the workplace – A survey on the experience of doctors in Singapore [Internet]. SMA News; 2010. Available at: http://news.sma.org.sg/4211/Violence.pdf. Accessed on 2 October 2015.
5. Danesh VC, Malvey D, Fottler MD. Hidden workplace violence: what your nurses may not be telling you. Healthcare Management (Frederick) 2008;27:357-63.
6. WSH Council (Singapore); Ministry of Manpower (Singapore). Workplace Safety and Health Guidelines on Healthcare. Singapore, Workplace Safety and Health Council; 2008 Apr.
7. Camerino D, Estryn-Behar M, Conway PM, van Der Heijden BI, Hasselhorn HM. Work-related factors and violence among nursing staff in the European NEXT study: a longitudinal cohort study. Int J Nurs Stud 2008;45:35-50.

8. Lanctôt N, Guay S. The aftermath of workplace violence among healthcare workers: a systematic literature review of the consequences. Aggression and Violent Behaviour 2014;19:492-501.
9. Lim J, Bogossian F, Ahern K. Stress and coping in Singaporean nurses: a literature review. Nurs Health Sci 2010;12:251-8.
10. Speroni KG, Fitch T, Dawson E, Dugan L, Atherton M. Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. J Emerg Nurs 2014;40:218-28;quiz 295.
11. Leka S, Jian A. Health Impact of Psychosocial Hazards at Work: An Overview [Internet]. World Health Organisation; Available at: http://whqlibdoc.who.int/publications/2010/9789241500272_eng.pdf?ua=1. Accessed on 2 October 2015.
12. Arnetz JE, Arnetz BB. Violence towards health care staff and possible effects on the quality of patient care. Soc Sci Med 2001;52:417-27.
13. Gerberich SG, Church TR, McGovern PM, Hansen HE, Nachreiner NM, Geisser MS, et al. An epidemiological study of the magnitude and consequences of work-related violence: the Minnesota Nurses' Study. Occup Environ Med 2004;61:495-503.
14. McPhaul KM, London M, Murrett K, Flannery K, Rosen J, Lipscomb J. Environmental evaluation for workplace violence in healthcare and social services. J Safety Res 2008;39:237-50.
15. Barish RC. Legislation and regulations addressing workplace violence in the United States and British Columbia. Am J Prev Med 2001;20:149-54.
16. Gorman T, Dropkin J, Kamen J, Nimbalkar S, Zuckerman N, Lowe T, et al. Controlling health hazards to hospital workers. New Solut 2013;23 Suppl:1-167.
17. Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. OSHA 3148-04R 2015. Washington, DC: US Department of Labor;2015.
18. Workplace Injury Compensation Act, Singapore Statutes, Chapter 354, No. 25 of 1975, Revised 2009 (July 31, 2009).
19. Xu G. Professional hospital violence: the pain that cannot be borne by Chinese medical practitioners. Am J Med Qual 2013;28:76-7.
20. Yu HX, Hu ZL, Zhang XF, Li B, Zhou SC. How to overcome violence against healthcare professionals, reduce medical disputes and ensure patient safety. Pak J Med Sci 2015;31:4-8.