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CLINICAL RESEARCH / KLİNİK ARAŞTIRMA

Invisible Victims of Violence in Healthcare Setting: A Survey-based Cross-sectional Study

Sağlık Sektöründe Şiddetin Gizli Mağdurları: Anket Tabanlı Kesitsel Bir Çalışma

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Abstract

Objective: The number and severity of violence in the health sector are increasing day by day. In many studies on violence in the healthcare sector, security and support service staff working in hospitals have been ignored. However, these people are also exposed to violence significantly. This study's primary purpose is to determine the frequency and characteristics of violence that the security and support service staffs are exposed to in the emergency department (ED) and other healthcare units.

Methods: This is a survey based, cross-sectional and descriptive study. Security staff and support services staff (data-entry clerk, cleaning, and patient transfer) were included in the study. Surveyors filled out the survey form face-to-face method. The violence was analyzed in four categories in this study: Physical, verbal, psychological, and sexual violence.

Results: After agreeing to participate, 439 volunteers included the study. The number of participants exposed to violence at least once during their work-life was 283 (64.5%), and exposed in the last year was 220 (50.1%). The rate of exposure to any violence in the last year was 75.7% for security staff, 42.9% for patient transfer staff, 32.5% for cleaning staff, and 47.5% for data-entry clerks. Being a security guard and working in the ED were identified as the most important factors for exposure to violence. Participants (n=335, 76.3%) mostly stated that the reason for the increase in violence in healthcare settings is the "density/crowd in hospitals and the related long waiting durations". The anxiety level about being exposed to violence while working was found to be higher in the ED staff (5 points on Likert type scale; 36.1% versus 23.7%; p=0.033).

Conclusion: The security and support service staff are frequently exposed to violence. Cautions should be taken to minimize the violence to which the staff is exposed; harsher punishments should be deterrent and applied immediately.

Keywords: Emergency department, healthcare, survey, violence

Öz

Amaç: Sağlık sektöründe yaşanan şiddetin sayısı ve ciddiyeti her geçen gün artmaktadır. Sağlık sektöründe şiddet konusunda yapılan birçok çalışmada hastanelerde çalışan güvenlik ve destek hizmetleri personeli görmezden gelinmiştir. Ancak bu kişiler de önemli ölçüde şiddete maruz kalmaktadır. Bu çalışmanın amacı, acil servis (AS) ve diğer sağlık birimlerinde çalışan güvenlik ve destek hizmetleri personelinin maruz kaldığı şiddetin sıklığını ve özelliklerini araştırmaktır.

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Öz

Yöntem: Anket tabanlı, kesitsel ve tanımlayıcı bir çalışmadır. Çalışmaya güvenlik ve destek hizmetleri personelleri (veri-giriş, temizlik, hasta taşıma personelleri) dahil edildi. Araştırmacılar anket formunu yüz yüze doldurdu. Bu çalışmada şiddet dört kategoride incelenmiştir: Fiziksel, sözlü, psikolojik ve cinsel şiddet.

Bulgular: Katılmayı kabul eden 439 gönüllü çalışmaya dahil edildi. Çalışma hayatı boyunca en az bir kez şiddete maruz kalanların sayısı 283 (%64,5), son bir yıl içinde şiddete maruz kalanların sayısı 220 (%50,1) idi. Son bir yıl içinde herhangi bir şiddete maruz kalma oranı güvenlik personelleri için %75,7, hasta taşıma personelleri için %42,9, temizlik personellleri için %32,5 ve veri girişi personelleri için %47,5 olarak tespit edildi. Güvenlik görevlisi olmak ve AS'de çalışmak şiddete maruz kalmanın en önemli faktörleri olarak belirlendi. Katılımcılar (n=335,%76,3) sağlık kuruluşlarındaki şiddetin artmasının nedeninin en çok "hastanelerdeki yoğunluk/kalabalık ve buna bağlı uzun bekleme süreleri" olduğunu belirtmişlerdir. AS'de çalışanlarda şiddete maruz kalma kaygısı diğer birimlerde çalışanlara göre daha yüksek tespit edildi (Likert tipi ölçekte 5 puan; %36,1'e %23,7; p=0,033).

Sonuç: Güvenlik ve destek hizmetleri personeli de sıklıkla şiddete maruz kalmaktadır. Personelin maruz kaldığı şiddeti en aza indirmek için alınacak önlemler arasında caydırıcı ve daha sert cezalar olmalı ve derhal uygulanmalıdır.

Anahtar Kelimeler: Acil servis, sağlık sektörü, anket, şiddet

Introduction

Violence is an important public health problem that is in all areas of life. It is defined as the purposeful application of physical violence, use of force, or threat to oneself, another person, group, or community in a way that may cause or result in death, physical injury, mental injury, and developmental disorder[1]. Workplace violence is defined as acts of violence (including physical assault and threats of assault) against people in the workplace or on a job[2]. Almost a quarter of workplace violence occurs in the healthcare sector worldwide[3]. Emergency departments (EDs) are the units where all kinds of violence occurred almost every day, and the problem of violence in health is experienced most frequently[4,5].

Studies on violence in the healthcare sector mostly focused on physicians, nurses, and paramedics. However, security and support service unit staffs are also exposed to violence during healthcare delivery. Exposure to violence and concerns about its recurrence may cause mental and physical injury or even death[6]. These individuals' careers and productivity are negatively affected, and workplaces have financial losses[6]. Also, this situation changes the attitudes and behaviors of the staff regarding their jobs. The security staff can consent to unfair requests to avoid intervening in violent acts. Correspondingly, healthcare services functioning is blocked, while the number and extent of violence against other healthcare professionals are increasing. The security staff is an essential part of the ED workforce in managing acts of violence[7,8]. They should also be involved in the solution process regarding the things to be done to prevent violence in health institutions[9].

The main purpose this study is to determine the security and support service staffs' frequency of violence exposure and differences in features and effects of violence between ED and other units. Our secondary aim is to determine the causes of violence in the healthcare sector and the need to be done to prevent it from their angle.

Materials and Methods

Study Design

This research is a survey-based, cross-sectional, and descriptive study. We obtained the local ethics committee approval (decision no: 2019/11-17) and the necessary permission documents before the study. Verbal consent was obtained from each participant before the survey application. Study data were collected between 01/10/2019-31/12/2019.

Study Population

The security and support services staff (data-entry clerk, cleaning, and patient transfer) working in a tertiary hospital for at least 12 months were included. And the hospital support and quality service unit informed all of them about the study. Surveyors filled out the survey face-to-face. Refusing to participate, did not complete the questionnaire, in staffs' day off or on sick leave was excluded.

Survey

The survey was designed after reviewing the relevant studies in the literature[4,10-12]. The final version of the survey was formed by interviewing 50 participants with a preliminary study that their data were not included. The survey was three main sections.

Sociodemographic information and descriptive characteristics of participants: The participants' age, gender, educational status, marital status, smoking status, alcohol use, position in the hospital, the number of years in this position, in which unit (ED or other healthcare settings) she/he worked in the last year, whether she/he worked in shifts, weekly working hours and job satisfaction states were questioned.

Frequency of participants' exposure to violence and characteristics of the last violence they experienced in the past year:

a. The frequency of exposure to violence was questioned during their entire work-life and in the last year.

b. The reason, type, perpetrator, and gender of the perpetrator, results of reporting the judicial units, and the reaction to the violence were asked. Exposing violence for participants, whether it changed their attitudes toward their jobs, and how they were affected were asked. Participants were asked to choose the most appropriate answer.

Participants' perspective on the causes of violence in the healthcare sector, the need to be done to prevent it, and the anxiety level about being violence:

a. The multiple-choice, open-ended questions were asked to evaluate the causes of violence and things that can be done to prevent violence.

b. Participants were asked to evaluate their anxiety about exposure to violence in their current job position using a 5-point Likert scale (1 point for never, 5 points for always).

Choosing Reference Standards

The violence was analyzed in four categories: Physical, verbal, psychological, and sexual violence. The definition of violence was accepted as recommended by World Health Organization[1]. Physical violence was accepted as any assault with or without tools that can lead to death, starting with intimidating the other person by using physical force. Verbal humiliation, insults, threats, and verbal attacks without physical contact were considered verbal violence. Psychological violence was accepted as a staff exposure to systematically applied intimidation by making them feel that they could use physical force and deliberate pressure to harm their physical, mental, spiritual, moral, or social development. Mobbing and deterrent behavior were also evaluated in this group. Sexual violence included committing a sexual act, unwanted sexual comments, making sexual approaches and proposals, or using a person sexually for commercial purposes[1]. During the question and answer session, the definition and types of violence were clearly explained to the participants.

Statistical Analysis

Categorical variables were examined with frequency tables; descriptive statistics were calculated for continuous variables. Pearson's chi-square test was used to analyze categorical data in terms of groups. The Shapiro-Wilk normality test was used to examine whether continuous variables were normally distributed in the groups. Since the numerical data were not normally distributed, the Mann-Whitney U test was used to compare the two independent groups' median values. The Kruskal-Wallis test was used to compare the median values in more than two independent groups. The significance level was taken as 0.05 in all hypothesis tests. IBM SPSS Version 25.0 statistical package program was used for statistical analysis.

Results

Sociodemographic Information and Descriptive Characteristics of Participants

Four hundred and thirty nine of 921 staff participated in the study. Of those, 56 (12.3%) were working in patient transfer, 111 (25.3%) were the security staff, 114 (26%) were cleaning staff, and 158 (36%) were working as a data-entry clerk.

The participants' median age was 37 (interquartile range: 12, min: 19, max: 58), 221 (50.3%) of those were female, 47.2% (n=207) of those were high school graduates, and 62% (n=272) of those were married. Those who did not use smoke (n=245, 55.8%) and alcohol (n=366, 83.4%) were predominant. Of the participants, 298 (67.9%) had been working for 1-10 years, 132 (30.1%) for 11-20 years, and 9 (2.1%) for more than 21 years. The participants' weekly working hours were 45 h. Two hundred twenty six (51.5%) participants work in shifts, and 144 (32.8%) of those working in the ED. The percentage of participants who are satisfied with their jobs was 77.9% (n=342).

Frequency of Participants' Exposure to Violence and Characteristics of the Last Violence in the Last Year

The number of participants exposed to violence at least once during their work-life was 283 (64.5%), and exposed in the last year was 220 (50.1%). The variables affecting violence

exposure are presented in Table 1. The rate of exposure to any violence in the last year was 75.7% for security staff, 42.9% for patient transfer staff, 32.5% for cleaning staff, and 47.5% for data-entry clerks. Being a security guard and working in the ED were identified as the most critical factors that cause exposure to violence. The half of the security staff had been exposed to violence more than five during their working life, and 48.8% experienced more than three in the last year. Also, the security staff was exposed to verbal violence most often (70.2%) in the last year. The physical violence exposure rate was the highest among the security staff than others. The rate of physical violence was 42.9% in security staff while it was 10.8% for cleaning staff, 20.8% in the patient transfer staff, and 26.4% in data-entry clerk (p<0.01). The ED staff were also frequently (79.8%) exposed to verbal violence, but the physical violence rates were higher than other units (34.8% versus 20.6%; p=0.019). Participants' violence exposure frequency according to their work area during their work-life and in the past year is shown in Figure 1.

Participants who were subjected to violence in the last year (n=128, 58.2%) stated that the reason for their most recent violence was "people's lack of knowledge about the functioning of the health system and hospital rules". The frequency of the reasons for the last violence participants exposed in the last year is shown in Figure 2. Participants were frequently exposed to verbal violence (n=173, 78.6%) by relatives (n=159, 72.3%) and men (n=159, 72.3%) and frequently gave verbal reactions (n=78, 35.5%). The judicial reporting rate was poor (n=39, 14.1%). Participants frequently chose the option "I encounter violence very often, I do not have time" (n=60, 31.7%) as the reason for not making a judicial report. In 5 (16.1%) of the judicial reports, the perpetrator had a money penalty, in 1 (3.2%) imprisonment, in 4 (12.9%) punished on both sides. After the violence, the

Table 1. Variables affecting exposure to violence

Characteristics of participants		Have you ever been exposed to violence during your work-life?		p	Have you been exposed to violence in the last year?		p
		Yes/total	%		Yes/total	%	
Department	ED	109/144	75.7	<0.01	89/144	61.8	<0.01
	Others	174/295	59		131/295	44.4	
Duration of work	1-10 years	188/298	63.1	0.226	149/298	50	0.933
	11-20 years	91/132	68.9		67/132	50.8	
	>20 years	4/9	44.4		4/9	44.4	
Duty	Security	98/111	88.3	<0.01	84/111	75.7	<0.01
	Patient transfer	36/56	64.3		24/56	42.9	
	Cleaning	50/114	43.9		37/114	32.5	
	Data entry	99/158	62.7		75/158	47.5	
Gender	Female	141/221	63.8	0.77	110/221	49.8	0.89
	Male	142/218	65.2		110/218	50.5	
Educational level	Primary education	40/84	47.6	<0.01	31/84	36.9	0.02
	High school	141/207	68.1		109/207	52.7	
	Higher education	102/148	68.9		80/148	54.1	
Marital status	Married	169/272	62.1	0.19	131/272	48.2	0.29
	Not married	114/167	68.3		89/167	53.3	
Cigarette	Users	118/194	60.8	0.15	86/194	44.3	0.03
	Non-smokers	165/245	67.3		134/245	54.7	
Alcohol	Users	43/73	58.9	0.27	29/73	39.7	0.05
	Teetotalers	240/366	65.6		191/366	52.2	
Working order	In shift	155/226	68.6	0.06	123/226	54.4	0.06
	Shiftless	128/213	60.1		97/213	45.5	

ED: Emergency department

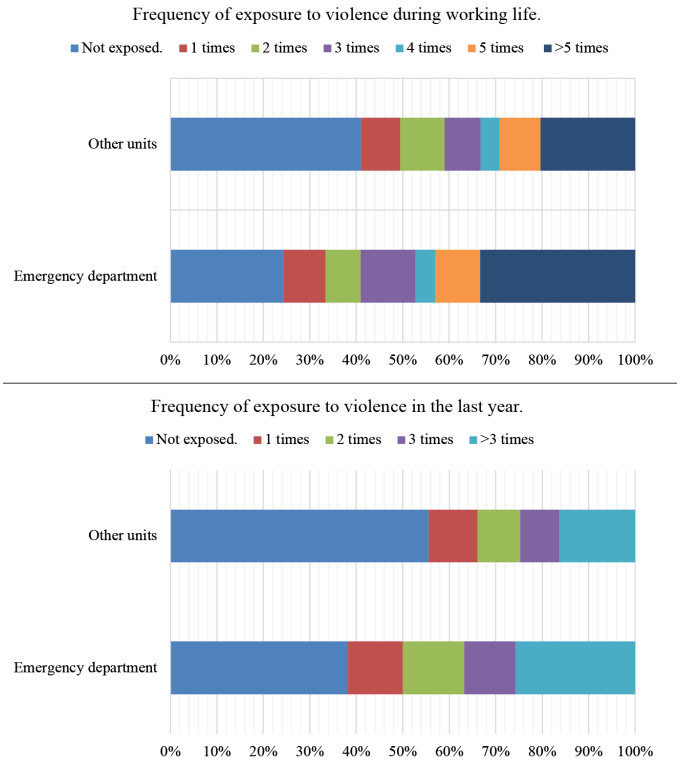

Figure 1. Participants violence exposure frequency according to their workplace

working attitude was no change for 64.1% (n=141) of the victims, but their rest have various changes. The participants of 49 (22.3%) stated that they fulfilled some unfair demands in order not to be subjected to violence again, 12 (5.5%) did not do their job willingly, 4 (1.8%) thought to quit their jobs, and 4 have different opinions. After the act of violence, participants' work attitude change rates were higher among ED staff compared to the other unit staff (43.8% vs 30.5%; p=0.024). The characteristics of the last violence that the participants were exposed to last year, compared to the unit they worked, are shown in Table 2.

Participants' Views About the Cause and Prevention of Violence, and Anxiety Level for Exposing Violence

Participants (n=335, 76.3%) mostly stated that the reason for the increase in violence in healthcare settings is the "density/crowd in hospitals and the related long waiting durations". The option "Legal punishments should be increased" was frequently selected (n=306, 69.7%) for the things to be done

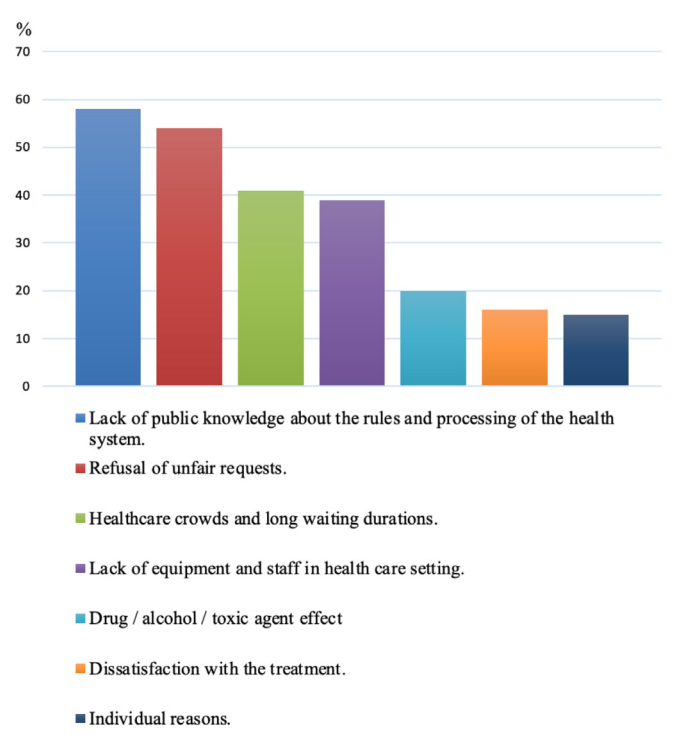

Figure 2. The frequency of the reasons for the last violence that participants exposed in the last year

to prevent violence. The participants' opinions about the causes of violence and thoughts for preventing violence are shown in Table 3 in order of frequency.

The level of anxiety about being exposed to violence while working was found to be higher in the ED staff (5 points on Likert type scale; 36.1% vs 23.7%; p=0.033). The anxiety level for exposing the participants' violence according to the unit they worked is shown in Figure 3.

Discussion

This study reveals the extent, causes, and resolution suggestions of the violence exposed by the staff working in security and other support services in the health sector. The percentage of participants exposed to violence at least once during their work-life was 64.5%, and exposure in the last year was 50.1%. The staff working in the ED was exposed to violence more than those working in other units during their working life and in the last year (p<0.01).

In a study involving all health professionals and covering seven countries, support services staff were also included among professional groups[13]. Exposure to violence has been found more common among support service staff in Thailand

Table 2. The characteristics of the last violence that the participants were exposed to the last year, compared to the unit they worked					
Characteristics of the violence	**ED**		**Others**		**p**
	n	**%**	**n**	**%**	
Type of violence (multiple answers can be given)					
Physical	31	34.8	27	20.6	0.019
Verbal	71	79.8	102	77.9	0.734
Psychological	16	18.0	15	11.5	0.172
Sexual	2	2.2	0	-	0.085
The perpetrator of violence (multiple answers can be given)					
Patient	23	25.8	41	31.3	0.382
Relative of the patient	73	82.0	86	65.6	0.008
Health care worker	4	4.5	13	9.9	0.139
Gender of the perpetrator					
Female	18	20.2	33	25.2	0.123
Male	64	71.9	95	72.5	
Both	7	7.9	3	2.3	
Reaction to violence					
I did not respond	22	24.7	39	29.8	0.787
I verbally responded	31	34.8	49	35.9	
I physically responded	6	6.7	7	5.3	
I called the security	30	33.7	38	29	
Judicial report					
Reported	17	19.1	14	10.7	0.078
Reason for not making a judicial reporting (multiple answers can be given)					
I encounter often; I do not have time	21	29.2	39	33.3	0.550
I do not think s/he will be fined	19	26.4	31	26.5	0.987
I do not want to deal	19	26.4	30	25.6	0.909
I could not get support from my institution	19	26.4	9	7.7	<0.01
I made peace with the other person	6	8.3	8	6.8	0.703
Financial insufficiency	3	4.2	1	0.9	0.124
I scared	2	2.8	2	1.7	0.620
Conclusion of the judicial report					
No lawsuit was filed	3	17.6	2	14.3	0.701
The lawsuit is ongoing	3	17.6	4	28.6	
S/he was served with fined	4	23.5	1	7.1	
Not fined	4	23.5	5	35.7	
S/he received imprisonment	1	5.9	0	-	
Both sides were fined	2	11.8	2	14.3	
Has this violence affected your job attitude? If yes, how?					
No, I keep doing my job as it should be	50	56.2	91	69.5	0.024
Yes, I can ignore some unfair things to avoid violence	24	27	25	19.1	
Yes, I do not do my job fondly	5	5.6	7	5.3	
Yes, I am thinking of quitting my job	10	11.2	4	3.1	
Other	-	-	4	3.1	
ED: Emergency department					

Table 3. The participants' opinions about the causes of violence and thoughts for preventing violence		
What do you think about the reason for the increase in violence in the health sector?		
Answers (multiple answers can be given)	**n**	**%**
Crowding in hospitals/long waiting durations	335	76.3
Lack of legal punishments for violence in health care settings	273	62.2
Low level of education	261	59.5
Lack of equipment and staff in health care settings	192	43.7
The negative effect of the media	96	21.9
Dissatisfaction with the treatment	86	19.6
High treatment costs	21	4.8
What do you think can be done to prevent violence in the health sector?		
Answers (multiple answers can be given)	**n**	**%**
Legal punishments should be increased	306	69.7
Social training and awareness should be provided	252	57.4
Legal support should be given to staff	232	52.8
Security preventions should be increased in health care settings	229	52.2
Crowding in the healthcare sector should be reduced	219	49.9
The deficiencies in the health sector (equipment/staff etc.) should be completed	208	47.4
The media should make publications condemning violence	151	34.4
Staff should be trained on alleviating violence	123	28

and Bulgaria, technical staff in South Africa, administrative staff in Brazil and Portugal, and allied healthcare workers (psychologists, social workers, occupational therapists, etc.) in Australia. All professions working in the healthcare sector are affected by the violence that has become "part of the job". In a nationwide survey was reported that 44.7% of health workers were exposed to any violence in the past year[10]. This rate was 41.8% for security staff and 21.4% for support service staff. Although exposure to violence are lower than physicians, the amount of violence to which the security and support service staff are exposed is considerable. In this study, the rate of exposure to any violence in the last year was 75.7% for security staff, 42.9% for patient transfer staff, 32.5% for cleaning staff, and 47.5% for data-entry clerks. The fact that this study was conducted using face-to-face interviews, the definition and types of violence were explained to the participants provided a better understanding of the subject and the awareness of neglected events.

A study in ED found that the participants of 72.3% were exposed to any violence in the last year, and the rate was higher among nurses (80.8%) and doctors (78%)[14]. The same study found clerks (80%) and physicians (100%) were exposed to verbal violence the most. In comparison, the security staff (80%) was exposed to threatening violence. In this study we found that security staff was exposed to any violence more than other unit's staff both during their working life and in the last year. While the security staff was exposed to verbal violence most frequently (70.2%) in the last year, the rate of being exposed to physical violence was higher than other unit's staff ($p<0.01$). This situation may be related to the security staff's involvement in all acts of violence due to their duties. For this reason, it is essential to educate the security staff to prevent violence, to intervene in violence, and what to do after violence. The security staff working in health facilities should be more qualified, and their authority should be increased. The need for experienced and specially trained security staff who will immediately respond to violence in EDs had been the subject of previous studies[7,8,14].

It was found that participants working in the ED were more likely to be exposed to violence during their working life (75.7% vs 59%; $p<0.01$) and within the last year (61.8% vs 55%; $p<0.01$) than those working in other departments. This study also found that the security staff, with high school and higher education levels, who do not smoke, and who do not use alcohol, were exposed to more violence last year. No relationship was found between gender, marital status, working hours, shift work pattern, and the frequency of exposure to violence. Pinar et al.[10] reported the risk factors

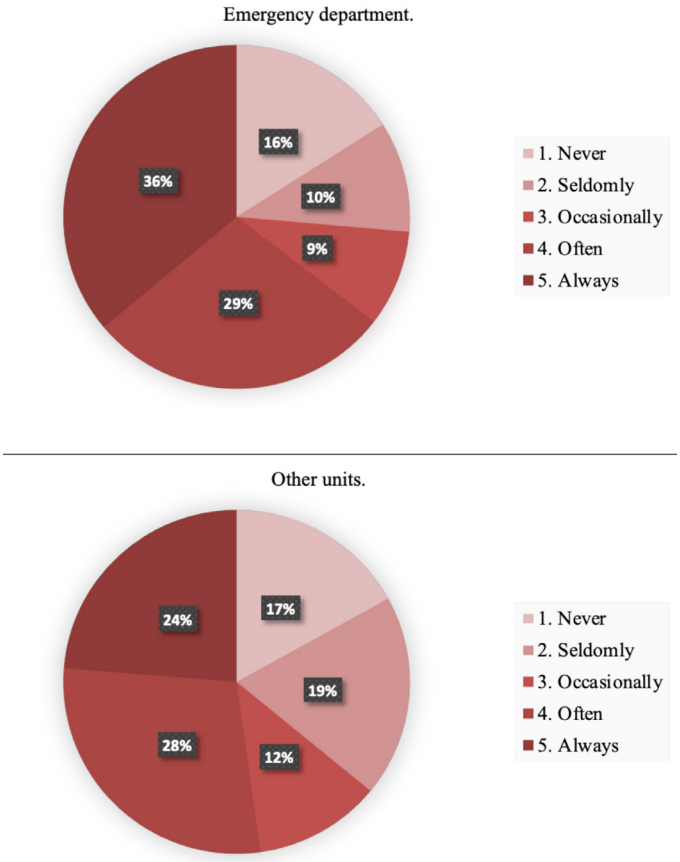

Figure 3. Anxiety level for exposing the participants' violence according to the unit they worked

for exposure to violence as health system level, institution type, gender, occupation, age, working between 18:00 and 07:00, and working in shifts in the last year. The relationship between exposure to violence and gender is associated with being a woman in many studies[5,14,15]. Some national studies showed that women are exposed to verbal violence more, and men are exposed to physical violence more[16,17]. A prospective study reported that the occupation made a difference, but gender, working hours, and being experienced did not make a difference for exposure to violence[18]. Risk factors causing violence are multifactorial and probably differ regionally. However, working in the ED stands out as a common cause in many studies[19-24].

In this study, 35.9% of the participants stated various negative changes in their work attitudes after the violence. After the act of violence, changes in work attitude were found higher among ED staff (43.8% vs. 30.5%; p=0.024). Participants mostly stated their anxiety level of being re-exposed to violence as often (4 points on Likert type scale; 28.5%) and always (5 points on Likert type scale; 27.8%). The level of anxiety about being exposed to violence while working was higher in the ED working group (5 points on Likert type scale; 36.1% vs 23.7%; p=0.033). A study examining the effects of violence on workers with ED shows that acute stress develops after exposure to violence significantly reduces workers' productivity[18]. A recent study reported that participants' fear of violence affected medical decision-making processes and changed their behavior not to be exposed to violence[25]. The adverse effects of violence are multifaceted due to both staff and patients.

In this study, the participants thought "density/crowd in hospitals and the related long waiting durations" were the most common reason for violence. Long waiting durations were reported as the most common cause in many studies[5,16,26]. However, those exposed to violence in the last year mostly (58.2%) stated that the reason for the most recent violence they were exposed to was "people's lack of knowledge about the functioning of the health system and hospital rules". It was followed by the rejection of unfair requests (54.1%), the crowd in hospitals, and the associated long waiting durations (41.4%). In this study, most participants (69.7%) thought that legal punishments should be increased for violence prevention. In this study, forensic reporting of violent incidents was insufficient (14.1%). Although it has been reported in the international literature that there are deficiencies in reporting violence, the reporting rates are higher than in our country[4,16,19,27]. The reason for this may be that the legal penalties given to those who use violence against healthcare professionals in our country are not deterrent. A study conducted in our country reported that most healthcare workers believed no punishment would be imposed on the aggressors even if the cases were reported[28].

Study Limitations

The retrospective preparation of the content of the questions asked in this study was one of the most important limitations. However, to minimize mistakes related to remembering, the characteristics of violence experienced in the last year were examined in more detail. Since the study is single-centered, results cannot be generalized. The socio-cultural factors of the community may also affect the results. Using more detailed questions could examine the effects of exposure to violence. However, as the number of questions increases, the rate of filling out the surveys decreases, so the number of questions has remained limited.

Conclusion

The support service staff working at important steps in the healthcare system are frequently exposed to violent incidents. Especially ED staff is concerned about being exposed to violence. This situation causes negative changes in job attitudes. Cautions should be taken to minimize the violence to which healthcare workers are exposed; harsher punishments should be deterrent and applied immediately.

Ethics

Ethics Committee Approval: The study was approved by the University of Health Sciences Turkey, İzmir Tepecik Education and Research Hospital Ethics Committee (decision no: 2019/11-17, date: 10.07.2019).

Informed Consent: Verbal consent was obtained from each participant before the survey application.

Peer-review: Externally peer-reviewed.

Authorship Contributions

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