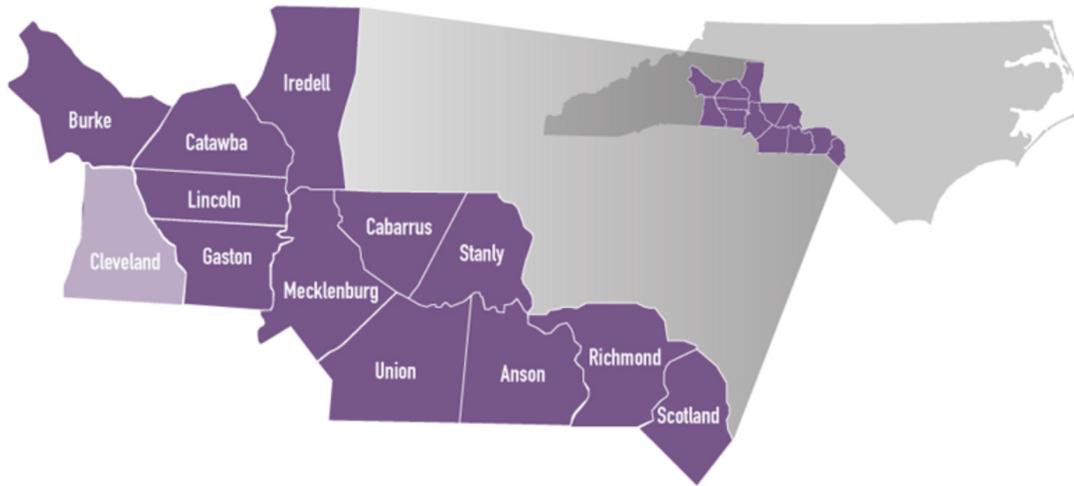


LONG TERM CARE NEWSLETTER

June, 2022

Volume 2 Issue 6



June, 2022:

REGIONAL UPDATE & WELCOME

Welcome

WRITTEN BY RONALD HENSCHTEL, MPH

Welcome to the June edition of the Long-Term Care newsletter. This month we will take a break from discussing COVID and all its variants and look at another area of preparedness, violence. Violence in workplaces can take many shapes. This month we will look at a few different forms of violence in the workplace among staff, residents, and visitors. We will also be looking at active shooter events in long-term care facilities and discussing training programs for the different forms of violence.

Finally, we want to take a moment to announce that we are working on a long-term care survey to help create the next 12 months of training and exercise offerings for you. If you would like to be added to our mailing list and receive the survey. Please reach out to any of the MHPC staff.

State Dashboard Data

DATA COLLECTED FROM STATE DASHBOARD

Cases and Deaths by Week

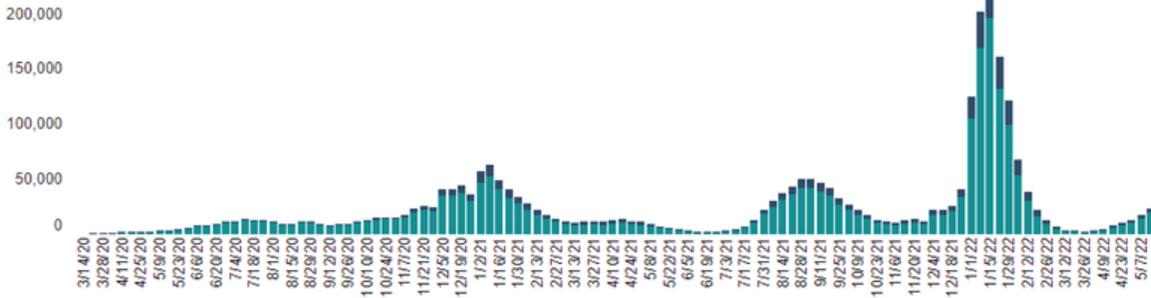
Select County

North Carolina

Select Week Ending Date

3/7/2020

Cases by Week of Specimen Collection for North Carolina - 3/7/2020 through Week Ending 5/21/2022



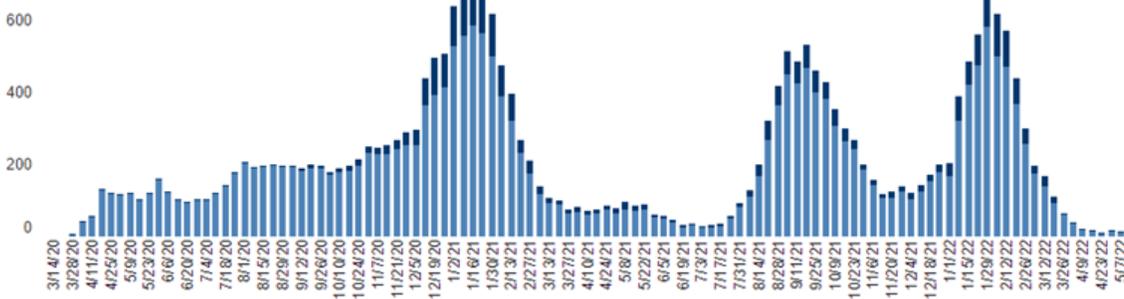
North Carolina
Total Cases
2,744,935

Molecular (PCR)
Positive Cases
2,287,127

Antigen Positive Cases
457,808

Specimen collection date missing for 92 of the total cases.

Deaths by Week of Death for North Carolina - 3/7/2020 through Week Ending 5/21/2022



North Carolina
Total Deaths
24,644

Molecular (PCR) Positive
Deaths
21,475

Antigen Positive Deaths
3,169

Date of death missing for 4 of the total deaths.

Hospitalizations Data: June 1, 2020 – May 21, 2022

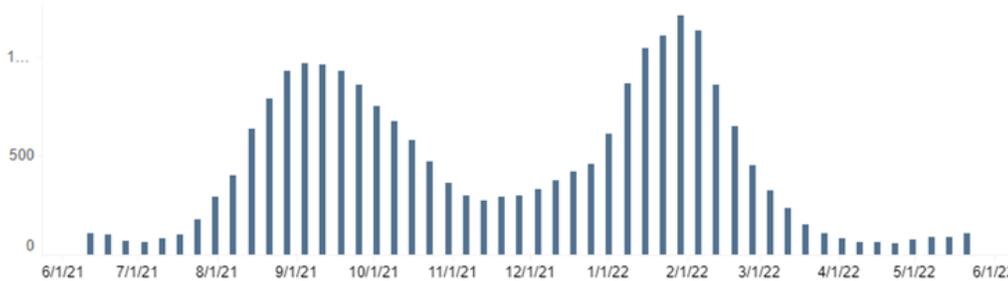
Last updated on May 25, 2022
Updated Every Wednesday.

- Statewide
- Region View

Filter By Region

MHPC - Metrolina Healthcare Preparedness Coalition

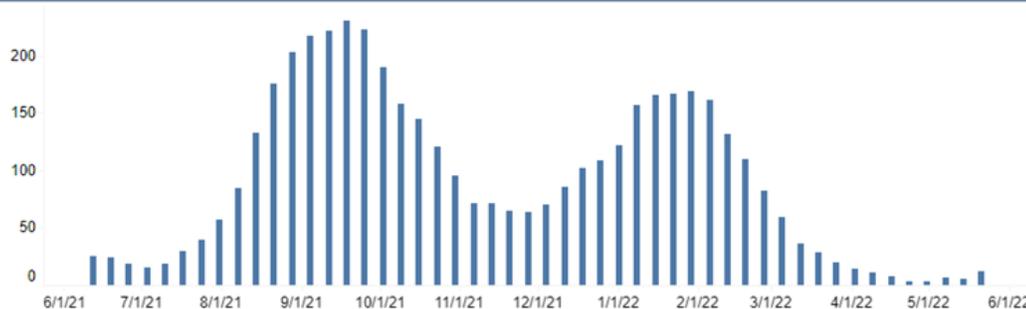
7-Day Average of COVID-19 Patients Hospitalized By Week | Statewide



109
7-Day Average of COVID-19
Patients Hospitalized By Week

100%
Hospitals Reporting

7-Day Average of Adult ICU COVID-19 Patients By Week | Statewide



- Adult ICU COVID-19 Patients
- New COVID-19 Patients Admitted

12
7-Day Average of
Adult ICU COVID-19 Patients By Week

State Dashboard Data

DATA COLLECTED FROM STATE DASHBOARD

Outbreaks Data will be updated every Wednesday.

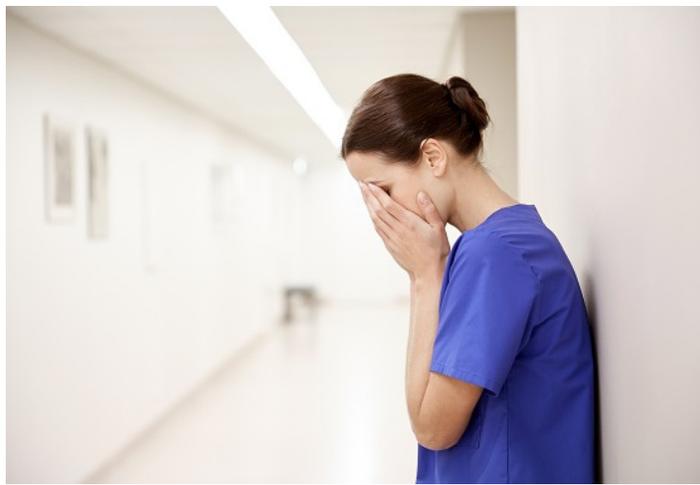
| Congregate Living Settings i | | |
|---|-------------|--------------|
| | Total Cases | Total Deaths |
| Nursing Home | 58,480 | 5,077 |
| Residential Care Facility | 29,047 | 1,704 |
| Correctional Facility | 24,766 | 121 |
| Other | 6,607 | 23 |
| Not Living/Working in Congregate Living Settings | 1,013,273 | 7,241 |
| Missing | 1,617,611 | 10,479 |

| Ongoing Congregate Living Outbreaks i | |
|--|-----|
| Nursing Home | 175 |
| Residential Care Facility | 103 |
| Correctional Facility | 26 |
| Other | 8 |

The above figures were gathered from the statewide COVID dashboard on June 01, 2022. The figures are compounding from the initial outbreak of COVID-19 (NCDHHS, 2021).

| County | Cases 04/06/2022 | Deaths 04/06/2022 | Cases 05/01/2022 | Deaths 05/01/2022 | Active LTC Outbreaks 05/01/2022 |
|-------------|---------------------|----------------------|---------------------|----------------------|---------------------------------------|
| Anson | 6,548 | 96 | 6,672 | 101 | 0 |
| Burke | 25,164 | 316 | 25,807 | 328 | 3 |
| Cabarrus | 56,031 | 468 | 58,060 | 494 | 6 |
| Catawba | 47,695 | 567 | 48,849 | 600 | 0 |
| Cleveland | 29,608 | 364 | 30,153 | 389 | 3 |
| Gaston | 65,451 | 794 | 67,085 | 852 | 7 |
| Iredell | 48,611 | 445 | 50,090 | 468 | 7 |
| Lincoln | 24,366 | 158 | 24,975 | 174 | 0 |
| Scotland | 10,052 | 126 | 10,349 | 132 | 0 |
| Stanly | 19,374 | 249 | 19,768 | 264 | 1 |
| Union | 61,999 | 479 | 64,414 | 491 | 4 |
| Mecklenburg | 280,946 | 1,558 | 293,852 | 1,622 | 22 |

The above figures were gathered from the statewide COVID dashboard and MPHC data collection on both May 02, 2022 and June 01, 2022. The figures are compounding from the initial outbreak of COVID-19 (NCDHHS, 2021).



LEV DOLGACHOV, SHUTTERSTOCK

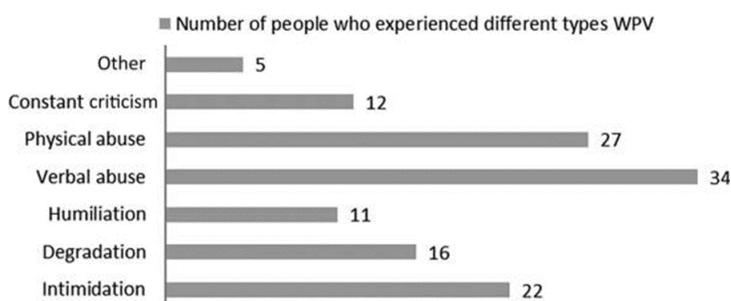
Violence in the Workplace

By Ronald J Henschel, MPH

Many forms of workplace violence can take place in the healthcare field. The most common one would be when dealing with residents with a level of mental impairment. Others would include dealing with the family of residents or a co-worker. We will discuss active shooter violence later in the newsletter.

Why address this now when the world is full of pandemics and other forms of horrible things? Employee burnout, all of the bad things happening globally, has led to an all-time high of burnout in healthcare workers. Before the pandemic, much research had been done about how workplace violence increased turnover rates in healthcare settings. A study conducted in multiple countries showed that workplace violence had significantly contributed to turnover rates prior to the pandemic in 2014. Often, reports of violence or bullying do not get reported ((Heponiemi et al., 2014). The key takeaway here is "not reported."

Why would a facility's staff not report such activity? Could it be a belief that management may not follow through with claims? Could the violence or bullying be from another employee? The responsibility for a safe environment always rests on the leader. Another pre-COVID study was conducted in the United States, working with 80 nurses and certified nursing assistants from three different facilities. The results showed that sixty-five percent of those long-term care workers experienced workplace violence. A staggering forty-one percent of that sample group believed that management shows little concern for their safety. Twenty-two percent believed their workplace was not safe to carry out their day-to-day duties (Fasanya & Dada, 2016). Maybe the most frightening part of the statistics was that eighty-eight percent of those that claimed to have been affected by workplace violence did NOT report it. Those eighty-eight percent believed that by reporting it, they could either lose their jobs or that the matter would not be handled appropriately by management (Fasanya & Dada, 2016).

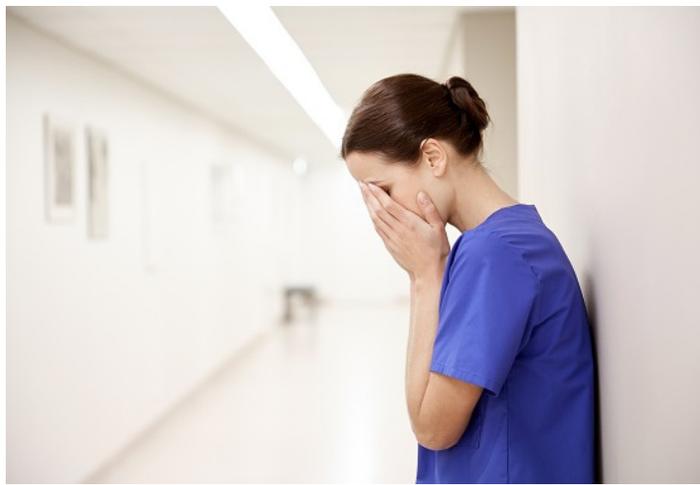


Rates of WPV perpetrators in long-term medical care facilities surveyed

| Sources | WPV (n) | Rate (%) |
|-------------------------|---------|----------|
| Visitors/patient family | 11 | 15.5 |
| Patients | 38 | 53.5 |
| Co-worker | 13 | 18.3 |
| Management | 9 | 12.7 |

WPV, workplace violence.

(Fasanya & Dada, 2016)

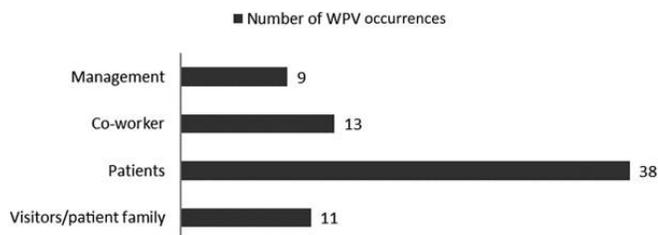


LEV DOLGACHOV, SHUTTERSTOCK

Violence in the Workplace

By Ronald J Henschel, MPH

Rates of WPV types in long-term medical care facilities surveyed



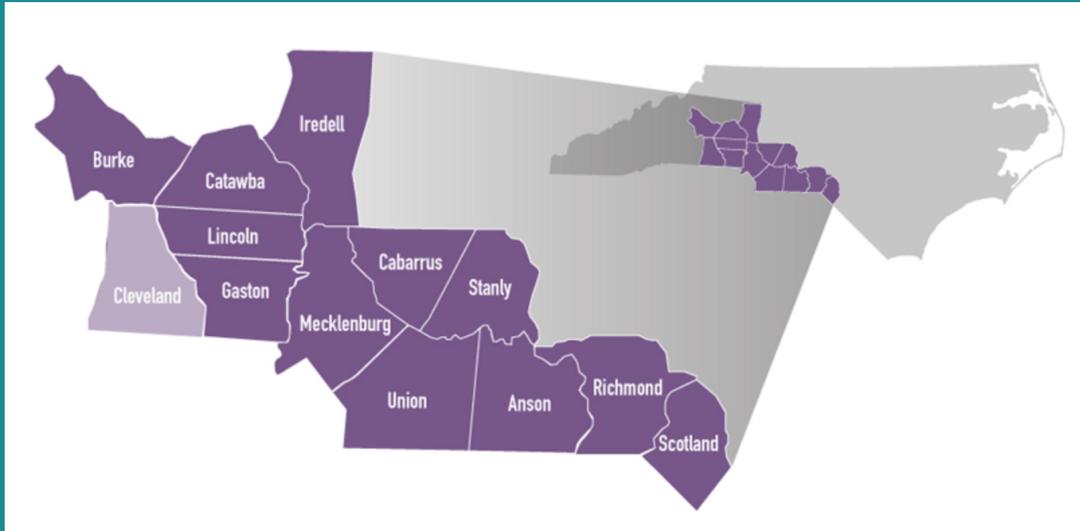
| WPV type | WPV type (n) | Rate (%) |
|--------------------|--------------|----------|
| Intimidation | 22 | 17.32 |
| Degradation | 16 | 12.60 |
| Humiliation | 11 | 8.66 |
| Verbal abuse | 34 | 26.77 |
| Physical abuse | 27 | 21.26 |
| Constant criticism | 12 | 9.45 |
| Other | 5 | 3.94 |

WPV, workplace violence.

(Fasanya & Dada, 2016)

The question that may be asked is, why view pre-pandemic studies about this? Our answer is simple: imagine what it is like now if this was a sample of how bad it was before the stresses of COVID. Two of the risk factors most associated with healthcare violence are low staffing and solo work with no easy access to employee backup. Both of those factors are exacerbated due to the pandemic. Add the stresses on employees, residents, and families of residents the pandemic brought forward, and the facility is now a powder keg.

Now maybe a good time to reflect on the facility's current program and the state of the work environment. Does the facility have a way for staff to call each other in an emergency? Do they have to "Holler down the hall" for help? How thorough is the investigation into workplace violence reports? Remember, a physical altercation is only one type of workplace violence. The Occupational Safety and Health Administration states that a violence prevention program must have these elements: management commitment and employee involvement, worksite analysis, hazard prevention and control, education and training, record-keeping, and constant evaluation of the program. Creating a safe environment can go a long way toward reducing employee turnover. In today's healthcare scene, if an employee does not feel safe in the workplace, it will not take them long to find a facility they do.



Education Corner

We have quite a few pieces of training listed on our website for you to take part in that may benefit the Long-Term Care Community.

June 2022

June 14th - 15th: Disaster Management for Electric Power Systems

August 2022

August 9th - 10th: Disaster Disaster Preparedness for Hospitals and Healthcare.

If you wish to attend any of these pieces of training, please go to our website at <https://metrolinapreparedness.org/upcoming-educational-opportunities>. You can also contact KC Bernesser for more information at kariena.bernesser@atriumhealth.org.

If there are any education offerings you would want to see that are more LTC-focused, we would love to hear from you. We have our contact information listed at the end of the newsletter.



(BOWERS)



Conversation Starter

Active Shooter

WRITTEN BY: RONALD J HENSCHEL, MPH

Every time a news program happens anymore, there seems to be pandemic news and acts of violence reported. During the latest school shooting, it was believed that the person may have wrecked their vehicle outside the school and entered it of convenience. What if that building was a long-term care facility? Are the facility's staff and residents as prepared as teachers and elementary school children are? In the past, the concept of an active shooter event in a long-term care facility would have been an afterthought when talking about possible events. However, today's world shows that any place where individuals are vulnerable may be a target. In 2009, here in North Carolina, that unthinkable scenario took place. In Carthage, NC, eight people died when a gunman walked into a long-term care facility. The Federal Bureau of Investigation reported sixty-one active shooter incidents in 2021. That was a fifty percent increase from 2020 (FBI, 2022). These cases were not healthcare facilities but all incidents of active shooters. Violent acts such as these are on the rise. There is only time standing in the way of the next long-term care incident.

The long-term care facility adds a dimension to preparing for a scenario like this that other venues do not have, the residents. Residents are here because they require constant help with day-to-day activities. Therefore, any training program that works with a long-term care facility will have to be tailored to that specific facility and the services the facility offers. Questions to ask include: What facility active shooter plans or armed assailant plans are in place, are the plans practiced, and is there a reasonable assumption that everyone in the building knows what to do? To continue under the assumption that this will not happen here will only leave a facility more vulnerable. It is time to start this conversation or review what plans are in place. Is the plan in place enough? Is it practical or realistic? Do local authorities know the plan, or have they been part of the training? Does the emergency plan have different actions and procedures for the various types of violent acts at a facility, i.e., active shooter, knife or blunt weapon, a physical altercation? In an article in the *Journal of Emergency Medical Services* discussing active shooters in healthcare settings, a valid point is made "people do not panic and make bad decisions because of too much information but rather from lack of guidance" (JEMS, 2020).

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IMAGE CITATION:

N.D., LEV DOLGACHOV/SHUTTERSTOCK.COM

BOWERS, A. (N.D.). PRIVACY. PHOTOGRAPH.



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