

Causes of workplace violence and preventive strategies in a tertiary care hospital in North India

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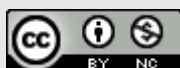
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ABSTRACT

Introduction: Workplace violence is a significant global issue, particularly in high-risk environments such as emergency departments (EDs) impacting the quality-of-care provision and mental health status of the health care professionals. This study aims to estimate the prevalence of workplace violence and its impact on employees working in emergency departments.

Methods: A descriptive study was conducted and 389 participants working in the emergency department and trauma centre were enrolled in the study consecutively using total enumeration sampling technique. The 'Workplace Violence in Healthcare Setting' questionnaire was used to assess the prevalence of workplace violence. Trauma Screening Questionnaire (TSQ) was used to evaluate an individual's responses to traumatic events. Interview was conducted along with the administration of questionnaire for data collection between March - April 2024.

Results: 179 (46%) participants were between 30 - 39 years old. 207 (53.4%) were Nursing officers, 66 (17%) were sanitary attendants, 48 (12.3%) were hospital attendants, 34 (8.70%) were doctors, 30 (7.7%) and 4 (1.02%) were security guards and lab technicians respectively. 360 (92.5%) participants out of total 389, faced verbal violence, and 100 (25.71%) encountered physical violence. The majority of the participants felt unrealistic expectations of the patients, inappropriate knowledge about disease conditions, lack of resources, overcrowding and long waiting time as the responsible factors for workplace violence.

Conclusion: Workplace violence in hospitals is linked to overcrowding, long wait times, inadequate knowledge, and lack of redressal systems. It may hamper care quality and staff morale. Preventive strategies include better resource management, communication skills, public education, infrastructure improvements, self-defense training, legislative measures, and effective complaint systems.

Keywords: Employees, Healthcare, Violence, Workplace.

Introduction

Workplace violence in healthcare settings, particularly in emergency departments (EDs), presents a significant global concern.¹ As per the World Health Organization and the International Council of Nurses, workplace violence includes abuse, threats, or assault, extending to commutes

to and from work. Workplace violence manifests physically (e.g., pushing, stabbing) and psychologically (e.g., threats of force), posing significant challenges for employees.²

It has been reported less by the employees, underestimating the true extent of the issue. In a

study from India, workplace violence was experienced by 34.5% of respondents over one year, with only 23.5% of incidents officially reported. The study also noted the lack of awareness about existing reporting mechanisms among healthcare workers. Nurses face heightened risks due to close patient interactions. They experience varying prevalence rates of workplace violence, ranging from 10 % to 87% globally.³ The National Institute for Occupational Safety and Health categorizes workplace violence into criminal intent, customer/client, worker-on-worker, and personal relationship types, each with distinct characteristics and implications.² Various risk factors contribute to escalating violence against healthcare workers, including patient and family behaviors, systemic issues like staff shortages and poor coping mechanisms, and environmental factors like overcrowded spaces and language barriers.⁴

The consequences of workplace violence extend beyond physical injuries to psychological effects, affecting individuals, organizations, and society at large. Irritability, difficulty concentrating, and thoughts of career change are common among healthcare workers who experience violence, highlighting the urgent need for comprehensive measures to address this pervasive issue and create safer work environments.⁵ The recently happened incident (Kolkata Rape-murder case) is a terrifying example of workplace violence. There is an urgent need for safety measures to be put in place for healthcare professionals.

Methods

A descriptive study design was adopted to assess workplace violence among employees working in the Emergency Departments of a tertiary hospital in North India. A total of 389 participants, comprising doctors, nurses, lab technicians, and security guards, were enrolled in the study using a total enumeration sampling technique. The participants included 34 doctors, 207 nursing officers, 4 lab technicians, 48 Hospital Attendants (HAs), 66 Sanitation Attendants (SAs), and 30 security guards. The study was approved by the

Ethics Committee of the Institute and permission for conducting research was taken from the concerned authorities. Written consent was obtained from the participants after ensuring anonymity and confidentiality of data. Apart from collecting the demographic & job profile of the employees, 'Workplace Violence in Healthcare Settings' and Trauma Screening Questionnaire (TSQ) were used to collect the data.

The Workplace Violence in Healthcare Setting is a 37-item questionnaire. It comprises of five sections and is aimed at evaluating the extent of the issue, identifying related risk factors, and proposing mitigation strategies. Section A includes two items designed to assess the frequency and types of violence encountered in healthcare settings. Section B, with eight items, investigates the impact of workplace violence on affected individuals, examining how it affects their personal lives, familial relationships, social interactions, and psychological well-being. Section C, comprising 11 items, explores the reasons for the under-reporting of violent incidents. Mitigation strategies to address workplace violence are examined in Section D, which contains 12 items. In contrast, Section E, with five items, highlights various risk factors contributing to violence in healthcare settings.⁶

The Trauma Screening Questionnaire (TSQ), is a self-report instrument designed to evaluate the individuals' responses to traumatic events. It includes 10 questions (yes/no response) that assess symptoms of re-experiencing and arousal, adapted from the post-traumatic stress disorder (PTSD) Symptom Scale (PSS-SR) by Foa et al. in 1993. A score of six or more positive responses indicates that the individual may be at risk for PTSD, suggesting the need for further evaluation.⁷

The study was approved by the Ethics Committee (EC/NINE/2024/5) and permission was sought from the Medical Superintendent to conduct the study in the emergency areas and the trauma centre. A list of employees working in the emergency ward was obtained from the

respective ward in-charges. Healthcare professionals working in the respective areas for more than 1 month and willing to participate were enrolled in the study, whereas those on any long leave were excluded. A total of 389 employees fulfilled the inclusion and exclusion criteria. The participants were approached in person, greeted, and explained about the purpose and nature of the study and were interviewed.

A written informed consent was obtained from all participants. They were assured of the

anonymity and confidentiality of their information. Doctors, nurses, and lab technicians were given self-administered questionnaires to fill out, which were collected at the end of the shift. In contrast, hospital attendants, sanitary attendants, and security guards were interviewed in person at their convenience. It was also ensured that the participants' routine work was not disrupted. Data was analyzed using IBM SPSS Statistics 20.

Results

According to the demographic and job profile, 101 (25.9%) participants were under 30 years old, while 179 (46%) were between 30 and 39 years old. The mean age \pm SD of participants was 32.27 ± 11.39 , with a range of 24 to 58 years. 222 (57%) of participants were unmarried. Females (67.7%) outnumbered males (32.3%).

Two hundred five participants (52%) were graduates. 149 (38.3%) participants had a total

working experience of 6-10 years. The mean \pm SD (range) of total working experience was 9.07 ± 5.903 (1 - 40 years). 151 (38.8%) participants had working experience of 6 -10 years, specifically in the emergency department/trauma centre. Mean \pm SD (range) of working experience in the emergency department/trauma centre was 5.49 ± 3.87 (1-25 years). [Table 1(a) and 1(b)]

Table 1 (a): Socio-demographic profile of the participants (N= 389)

Variables	n (%)
Age (in years) *	
<30	101 (25.9)
30-39	179 (46.0)
40-49	86 (22.1)
50-60	23 (5.90)
Marital status	
Unmarried	222 (57.1)
Married	167 (42.9)
Gender	
Female	264 (67.7)
Male	126 (32.3)
Qualifications	
Graduate	205 (52.7)
Undergraduate	129 (33.2)
No formal education	29 (07.5)
Postgraduate	26 (06.7)
Religion	
Hindu	266 (68.40)
Sikh	92 (23.70)
Muslim	19 (04.90)
Christian	12 (03.10)

Table 1(b): Job profile of the participants (N = 389)

Variables	n (%)
Designation	
Nursing officer	207 (53.4)
Sanitary attendant	66 (17.0)
Housing attendant	48 (12.3)
Doctors	34 (8.0)
Lab technicians	4 (1.02)
Security guards	30 (7.7)
Total working experience*	
<1year	25 (6.42)
1-5	88 (22.6)
6-10	149 (38.3)
11-15	73 (18.7)
15 and above	54 (13.33)
Working experience in emergency department/trauma centre**	
<1year	48 (12.3)
1-5	139 (35.7)
6-10	151 (38.8)
11 and above	51 (13.1)

One-third, i.e., 137 (35.2%) participants, experienced verbal altercations about once a year or less, while around one-fourth, i.e., 90 (23.1%) participants, experienced verbal altercations daily (Figure 1). Three hundred sixty participants (92.5%) experienced verbal altercations (threats,

abuse, exaggerated arguments, offensive comments, etc.) at some point during their working period (Figure 1), whereas 100 (25.7%) participants experienced physical violence mainly in the form of pushing and shoving (Figure 2).

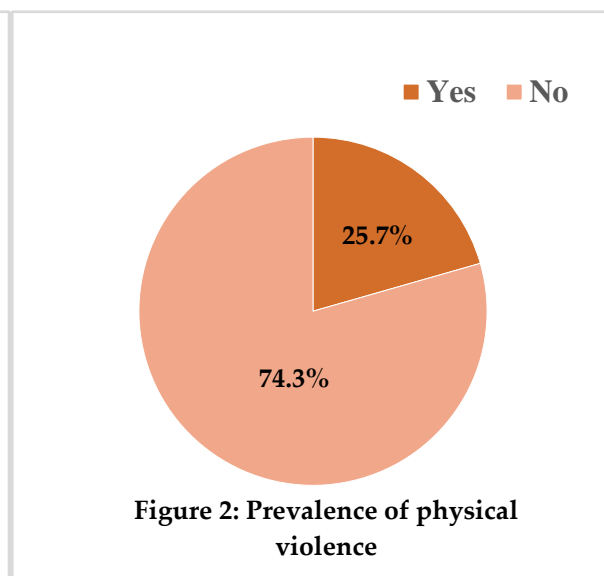
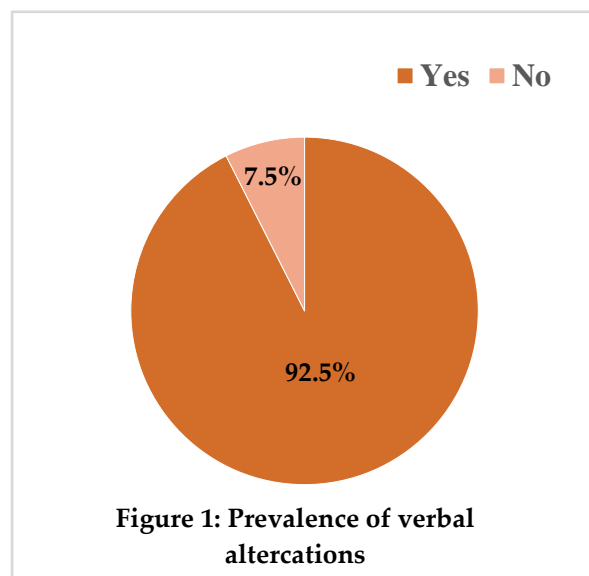


Table 2 represents the frequency of verbal altercations experienced by healthcare professionals. Thirty-six (54.6%) SAs experienced verbal altercations about once a year or less, 13 (38.2%) doctors experienced them nearly daily, 76

(36.7%) nurses experienced them about once a year or less, and 14 (46.6%) security guards experienced them about once a month. Two (50%) of the lab technicians experienced them nearly daily, while the other half experienced them about once a month.

Table 2: Frequency of verbal altercations (e.g., threats, abuse, exaggerated arguments, offensive comments, etc.) experienced by the participants (N=389)

Variables	Nearly daily n (%)	About once a month n (%)	About once every six months n (%)	About once a year or less n (%)	Never n (%)
Doctors(n=34)	13 (38.2)	3 (8.8)	9 (26.5)	8 (23.5)	1 (2.9)
Nurses(n=207)	54 (26.2)	33 (16.0)	31 (14.9)	76 (36.7)	13 (6.2)
HA(n=48)	4 (8.3)	16 (33.3)	6 (12.5)	15 (31.3)	7 (14.6)
SA(n=66)	7 (10.6)	8 (12.1)	8 (12.1)	36 (54.6)	7 (10.6)
Lab technicians (n=4)	2 (50.0)	2 (50.0)	--	--	--
Security guards (n=30)	10 (33.3)	14 (46.6)	3 (10.0)	2 (6.6)	1 (3.3)

Table 3 portrays the frequency of physical altercations experienced by different categories of study participants. 24 (70.6%) doctors, 168 (81.1%) nursing officers, 41 (85.4%) HAs, 55 (83.3%) SAs and 18 (60 %) of security guards have never experienced physical violence.

Table 3: Frequency of physical violence (e.g., slapping, beating, thrashing, vandalizing, attack with weapons, etc.) experienced by various employees (N=389)

Variables	About once in a month or more n (%)	About once every six months n (%)	About once a year n (%)	Less than once a year n (%)	Never n (%)
Doctors (n=34)	--	3 (8.8)	4 (11.8)	3 (8.8)	24 (70.6)
Nurses (n=207)	11 (5.3)	6 (2.9)	6 (2.9)	16 (7.8)	168 (81.1)
HA (n=48)	2 (4.2)	2 (4.2)	3 (6.2)	--	41 (85.4)
SA (n=66)	2 (3.0)	1 (1.5)	2 (3.0)	6 (9.1)	55 (83.3)
Lab technicians (n=4)	1(25.0)	3(75.0)	--	--	--
Security guards (n=30)	4 (13.3)	2(6.6)	4 (13.3)	2(6.6)	18 (60.0)

The impact of violence was assessed on the feelings and various aspects of the participants' lives as per the Workplace Violence in Healthcare Settings Questionnaire. 16 (47.1%) doctors and 4 (100%) lab technicians felt their motivation/efficiency was reduced at work, whereas 108 (52.1%) nurses, 35 (73.0%) HAs, 48 (72.7%) SAs, and 17 (56.6%) security guards were not affected at all by the episodes of violence.

Assessing the impact of the episodes of violence on various aspects of participants' lives, it was found that more than half of study participants

had no effect on their personal well-being, family life, or social life, whereas 208 (53.5%) participants had a mild effect on their mental and psychological well-being (Table 4).

When asked about the level of comfort while reporting the incidents of workplace violence, 14 (41.1%) doctors, 66 (31.9%) nurses, and 27 (40.9%) SAs were comfortable enough while reporting the incidents of workplace violence whereas 24 (50%) HAs, 3 (75%) lab technicians, and 20 (66.6 %) security guards gave neutral responses (Table 5)

Table 4: Impact of the episodes of violence on the feelings of the employees

(N = 389)

Variables	Did not/doesn't affect at all n (%)	Feel/felt that motivation/efficiency reduced at work n (%)	Feel/felt like changing workplace n (%)	Feel/felt like opting for an alternate career n (%)	Feel/felt like not working at all n (%)	Have/had self-harm/suicidal ideations n (%)
Doctors (n=34)	5 (14.7)	16 (47.1)	--	11 (32.4)	2 (5.9)	--
Nurses (n=207)	108 (52.1)	43 (20.8)	30 (14.5)	18 (8.7)	8 (3.8)	--
HA (n=48)	35 (73.0)	9 (18.8)	2 (4.1)	1 (2.1)	1 (2.0)	--
SA (n=66)	48 (72.7)	10 (15.2)	7 (10.6)	--	1 (1.5)	--
Lab technicians (n=4)	--	4 (100.0)	--	--	--	--
Security guards (n=30)	17 (56.6)	7 (23.3)	3 (10.0)	1 (0.3)	--	2 (6.6)

Table 5: Level of comfort while reporting the incidents of workplace violence (N = 389)

	Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)
Doctors (n=34)	2 (5.8)	--	11 (32.3)	7 (20.5)	14 (41.1)
Nurses (n=207)	18 (8.7)	4 (1.9)	57 (27.5)	62 (30.0)	66 (31.9)
HA (n=48)	--	5 (10.4)	24 (50)	3 (6.3)	16 (33.3)
SA (n=66)	8 (12.1)	5 (7.5)	19 (28.7)	7 (10.6)	27 (40.9)
Lab Technicians (n=4)	--	--	3 (75)	1 (25)	--
Security Guards (n=30)	2 (6.6)	--	20 (66.6)	7 (23.3)	1 (3.3)

When the reasons for not reporting workplace violence incidents were explored further, 174 (44.7%) participants felt ashamed of reporting, 190 (48.8%) believed that no action would be taken against the perpetrator, 140 (36%) participants felt that there was a lack of organizational support, and 146 (37.5%) reported this process as time-consuming. 198 (50.9%) participants feared that their appraisal/promotion avenues would be affected.

The mitigation strategies perceived by employees were effective in preventing episodes of workplace violence. Most of the participants felt that educating patients and attendants about the limitations of medical sciences and available infrastructure and improving health care and infrastructural facilities would be very useful in

preventing episodes of workplace violence (Table 6).

The majority of the participants felt that unrealistic expectations of the patients, inappropriate knowledge about disease conditions, lack of resources, overcrowding, and long waiting times might be responsible for workplace violence.

Table 7 represents risk factors associated with incidents of Workplace violence perceived by the participants. The majority of the study participants felt that unrealistic expectations of the patients, inappropriate knowledge about the disease condition, lack of resources, overcrowding, and long waiting times might be responsible for workplace violence.

Table 6: Perceived Mitigation Strategies useful in preventing the episodes of workplace violence (N = 389)

Statements	Very useful n (%)	Somewhat useful n (%)	Not useful n (%)
Controlling no. of attendants visiting the hospital with patient.	325 (83.5)	64 (16.5)	--
Educating patients and attendants about limitations of medical sciences and available infrastructure	340 (87.4)	48 (12.3)	1 (0.3)
Regular training of healthcare workers regarding soft skills	312 (80.2)	75 (19.3)	2 (0.5)
Self -defense training to healthcare workers	272 (69.9)	87 (22.4)	30 (7.7)
Improving health care facilities	352 (90.5)	35 (9.0)	2 (0.5)
Improving facilities within the hospital	309 (79.4)	76 (19.5)	4 (1.0)
Improving infrastructural facilities	341 (87.7)	45 (11.6)	3 (0.8)
Active complaint redressal system	328 (84.3)	54 (13.9)	7 (1.8)
Strong legislature measures (providing punishment to offenders)	329 (84.6)	55 (14.1)	5 (1.3)
Unbiased media reporting	230 (59.1)	126 (32.4)	33 (8.5)

Table 7: Perceived risk factors associated with incidents of Workplace violence in healthcare settings. (N = 389)

Variables	Very useful n (%)	Somewhat useful n (%)	Not useful n (%)
Unrealistic expectations of the patient.	335 (86.1)	50 (12.9)	4 (1.0)
Inappropriate knowledge about disease condition	343 (88.2)	42 (10.8)	4 (1.0)
Poor communication skills	302 (77.6)	81 (20.8)	6 (1.5)
Lack of resource	347 (89.2)	40 (10.3)	2 (0.5)
Overcrowding	375 (96.4)	14 (3.6)	--
Long waiting time	352 (90.5)	34 (8.7)	3 (0.8)
Inadequate security arrangements	311 (79.9)	69 (17.7)	9 (2.3)
Inadequate action on receiving complaints of workplace violence	306 (78.7)	71 (18.3)	12 (3.1)
Lack of respect for the authority of doctors/healthcare workers	299 (76.9)	79 (20.3)	11 (2.8)
Negative and inappropriate media reporting	237 (60.9)	97 (24.9)	55 (14.1)
Lack of the provision of harsh punishment for aggressors/offenders	303 (77.9)	75 (19.3)	11 (2.8)
Lack of redressal system	314 (80.7)	64 (16.5)	11 (2.8)

Table 8 (a) unfolds the number of participants who are at a risk of Post Traumatic Stress Disorder (PTSD) as assessed by the Trauma Screening Questionnaire (TSQ) by exploring personal reactions to the traumatic event if experienced at least twice in the past week. Eighteen (27.3%) sanitary attendants (SAs) had upsetting thoughts and memories about the event against their will. Thirteen (43.3%) security guards were upset by reminders of the event experienced. Eighteen

(52.9%) doctors and 99 (47.8%) Nursing officers experienced irritability or outbursts of anger, whereas 15 (44.1%) doctors had difficulty in concentrating due to episodes of workplace violence.

Table 8 (b) represents the participants' reaction to the traumatic events as per the Trauma Screening Questionnaire. The majority (91.53%) of the study participants were not affected by the traumatic

event as per TSQ (score of < 6), hence no psychiatric counselling support was availed. However, participants having a score of more

than 6 depict that they might be at risk of developing PTSD and would require psychiatric support.

Table 8 (a): Risk of Post Traumatic Stress Disorder (PTSD) of the participants as per Trauma Screening Questionnaire (TSQ) (N = 389)

Variables	Doctors n (%)	Nurses n (%)	HA n (%)	SA n (%)	Lab Technicians n (%)	Security Guards n (%)
Upsetting thoughts or memories about events against your will	8 (23.5)	53 (25.6)	4 (8.3)	18 (27.3)	--	6 (20.0)
Upsetting dreams about the event	1 (2.9)	13 (6.3)	1 (2.1)	8 (12.1)	--	5 (16.7)
Acting or feeling as though the event were happening again	3 (8.8)	32 (15.5)	5 (10.4)	6 (9.1)	--	2(6.7)
Feeling upset by reminders of the event	11 (32.4)	87 (42.0)	11 (22.9)	17 (25.8)	--	13 (43.3)
Bodily reactions when reminded of the event	4 (11.8)	25 (12.1)	--	7 (10.6)	--	2 (6.7)
Difficulty falling or staying asleep	6 (17.6)	47 (22.7)	5 (10.4)	17 (25.8)	--	2 (6.7)
Irritability or outbursts of anger	18 (52.9)	99 (47.8)	11 (22.9)	23 (34.8)	1 (25)	10 (33.3)
Difficulty concentrating	15 (44.1)	67 (32.4)	10 (20.8)	13 (19.7)	--	3 (10.0)
Heightened awareness of dangers to self and others	6 (17.6)	31 (15.0)	7 (14.6)	9 (13.6)	--	5 (16.7)
Being jumpy or being startled at something unexpected	3 (8.8)	16 (7.7)	4 (8.3)	6 (9.1)	--	--

8 (b): Reaction of participants to the traumatic events as per Trauma Screening Questionnaire (TSQ) (N=389)

Scoring	Doctors (n=34)	Nurses (n=207)	HA (n=49)	SA (n=66)	Lab Technicians (n=4)	Security guards (n=30)	Total N=389
Less than 6	30 (88.2%)	185 (89.37%)	48 (97.9%)	60 (90.9%)	4 (100%)	30 (100%)	323 (83%)
6 or >6 (need counselling support)	04 (11.8%)	22 (10.62)	01 (2.0)	06 (9.09)	--	--	33 (8.48%)

Discussion

Workplace violence in healthcare affects 62% of workers, with verbal abuse (58%), threats (33%), and sexual harassment (12%) being the most common forms of non-physical aggression.⁸

The study assessed workplace violence prevalence among 389 Emergency Department employees, achieving a 97% response rate despite non-participants citing time constraints. A similar study by Lindquist et al. reported a 95%

response rate with 386 participants. High response rates are crucial for data accuracy and representativeness, enhancing data quality and community engagement.⁹

The mean age of participants was 32.27 years, ranging from 24 to 58 years, with nearly half aged 30-39. Similar findings were noted in a study conducted by Shahjalal et al. (2021), which stated that most employees were <40 years of age.¹⁰

The majority of participants were Hindu (68.40%) and Sikh (23.70%), reflecting the demographics of Northern India. Over half were graduates, with one-third holding postgraduate degrees. The average work experience was 9.07 years, and 38.8% had 1-6 years of experience. These results align with the study by Munta et al., who found 45% had 1-5 years of experience.¹¹

In this study, nearly one-third (35.2%) of employees experienced verbal altercations annually, while 23.1% faced them daily. The prevalence of verbal abuse among nurses was 94.8%, contributing to an overall rate of 92.5% among healthcare professionals. Most verbal abuse stemmed from patients' attendants under stress due to extended hospital stays. These results align with Kaur et al.'s findings of 99% prevalence of verbal abuse among nurses. In contrast, Ori et al. reported that verbal threats (56.11%) were the most common form of workplace violence among postgraduate students in a tertiary care hospital in Manipur.¹²⁻

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In this study, 74.29% of participants reported no physical violence, while 25.71% did experience it. This aligns with the findings of a study by Kumar et al., who found that 8.6% of doctors faced physical violence. Age was not linked to verbal or emotional violence, but younger doctors were more likely to report physical violence.¹⁴

The current study examines the impact of workplace violence on healthcare professionals' feelings. Findings show mixed responses: while many doctors and nurses consider changes due to violence, most health assistants (HAs) and support assistants (SAs) reported no effects. This suggests differences in job roles, exposure, coping strategies, or attitudes toward violence, highlighting the need for targeted interventions to enhance workplace safety.

Regarding personal well-being, 61.2% of participants reported no impact on their overall health, 62.7% felt their family life was unaffected, and over half noted no effect on their social lives. Nearly half reported no impact on their mental

well-being. Most participants had over 10 years of experience, allowing them to develop coping mechanisms, though newly recruited staff were more affected.

A study by Vento et al. outlined severe consequences of violence against healthcare workers, including fatalities, job dissatisfaction, increased leave, impaired performance, depression, and PTSD. Workplace violence is also linked to higher burnout rates, reduced patient safety, and increased adverse events, emphasizing the need for effective support systems.¹⁵

Regarding incident reporting, 48.8% of participants felt no action would be taken against perpetrators, 36.8% cited a lack of organizational support, and 37.5% found the process cumbersome. Many believed reporting was futile due to time constraints and the absence of an effective redressal system. Kvas et al. noted similar concerns, including fear of job loss.¹⁶

The current study found that most employees believe mitigating workplace violence requires controlling patient load, improving healthcare infrastructure, establishing an active complaint redressal system, and stronger legislation against perpetrators. Similarly, Kumar PN et al. emphasized that administrators should address each contributing factor individually, including training programs for nurses in customer relationship management and interpersonal skills.¹⁷

A study by Lovell et al. identified key risk factors for workplace violence, including stressful environments from long hours, high patient loads, and critical decisions. Poor communication among health professionals, patients, and families also leads to increased verbal abuse. Resource shortages, like staff gaps and long wait times, further heighten tensions, raising the risk of both verbal and physical abuse.¹⁸

These findings align with the current study, in which 86.1% of participants identified factors such as unrealistic patient expectations, lack of resources, overcrowding, and long wait times as

causes of workplace violence. Using the Trauma Screening Questionnaire, 52.9% of doctors and 47.8% of nursing officers reported irritability and anger, while 27.3% of sanitary attendants experienced distressing memories. A study by Tawiah et al. noted that many healthcare workers remained highly alert after incidents of violence.¹⁹

This aligns with the study by Adatara et al. in Ghana, where nurses reported heightened vigilance after exposure to violence. Ongoing threats and the psychological impact of physical and verbal abuse leave healthcare workers feeling unsettled and perceiving continuous danger. The unpredictable nature of these incidents compels them to remain alert and prepared for potential future threats.²⁰

The current study found that most employees did not require psychiatric counselling, scoring less than 6 on the Trauma Screening Questionnaire after experiencing workplace violence, while others were advised to seek support. This highlights the ongoing psychological burden of verbal violence and underscores the need for effective institutional strategies. Addressing workplace violence necessitates a comprehensive approach, including:

- A commitment from healthcare management with clear policies and training.
- Healthcare workers' dedication to increasing their awareness.
- Technical support from organizations, NGOs, and the community to mitigate the impact of such incidents.

These approaches align with the study by Do SM et al in Vietnam where they emphasized on appropriate training on how to respond and report exposure to workplace violence among nursing students.²¹

Limitations

The study is limited to healthcare professionals working in hospital Emergency Departments. As workplace violence incidents were self-reported, there may be recall bias among participants.

Conclusions

The study findings revealed that all participants experienced some degree of job stress, with 65.5% falling into the low-stress group and 34.5% into the high-stress group. Occupational stress in white-collar workers was higher than in blue-collar workers. Employees with more work experience have higher job stress, suggesting that cumulative exposure to work-related stressors over time increases stress levels. The presence of stressors at work is effective in creating occupational stress.

Participants with high occupational stress were more likely to experience symptoms of anxiety, depression, and stress compared to those with low occupational stress levels. This relationship persisted across various demographic and occupational groups. Moreover, adjusting for demographic variables (age, sex, education), work-related factors (work experience, exercise, job type), and lifestyle factors (shift work, smoking, marital status) confirmed that higher occupational stress levels were associated with increased risks of mental health symptoms.

Linear regression analysis was applied to predict the factors involved in creating occupational stress. In this analysis, the relationship between the blue and white collars, work experience (years of employment), exposure to noise and stressors at work, and having symptoms of depression with occupational stress were statistically significant.

The study revealed that workplace violence is prevalent in hospitals and is significantly linked to factors such as overcrowding, long waiting times, inadequate knowledge, lack of a redressal system, and a lack of respect for employees. Workplace violence is a critical issue in healthcare settings, making it difficult for healthcare professionals to deliver quality care to patients and provide effective counselling to their caregivers. The findings suggested that preventive strategies to reduce workplace violence include controlling the number of patients' caregivers, educating them about the patient's condition, improving infrastructure,

enhancing soft-spoken skills, providing self-defense training, implementing strong legislative measures, and establishing active complaint redressal systems.

Recommendations

It is recommended to incorporate inter-professional education (IPE), offer training in prevention, de-escalation, and use of simulations,

and counselling and establish clear policies defining violence, reporting procedures, and consequences regarding workplace violence. It is also recommended to further enforce a zero-tolerance policy, ensure staff awareness, install panic buttons, and foster respect. There is a need to promote collaboration among staff, administration, and security for comprehensive solutions.

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